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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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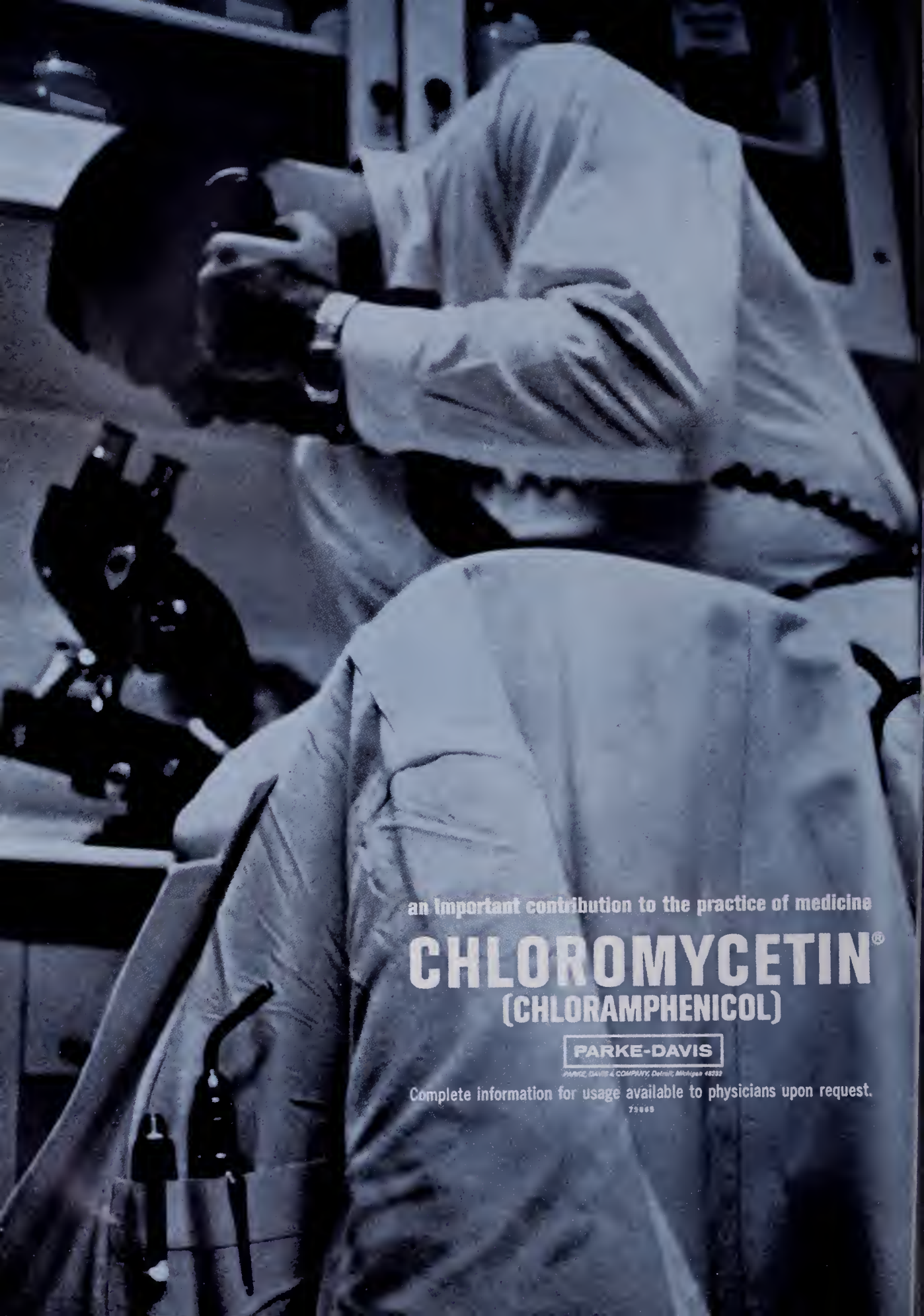
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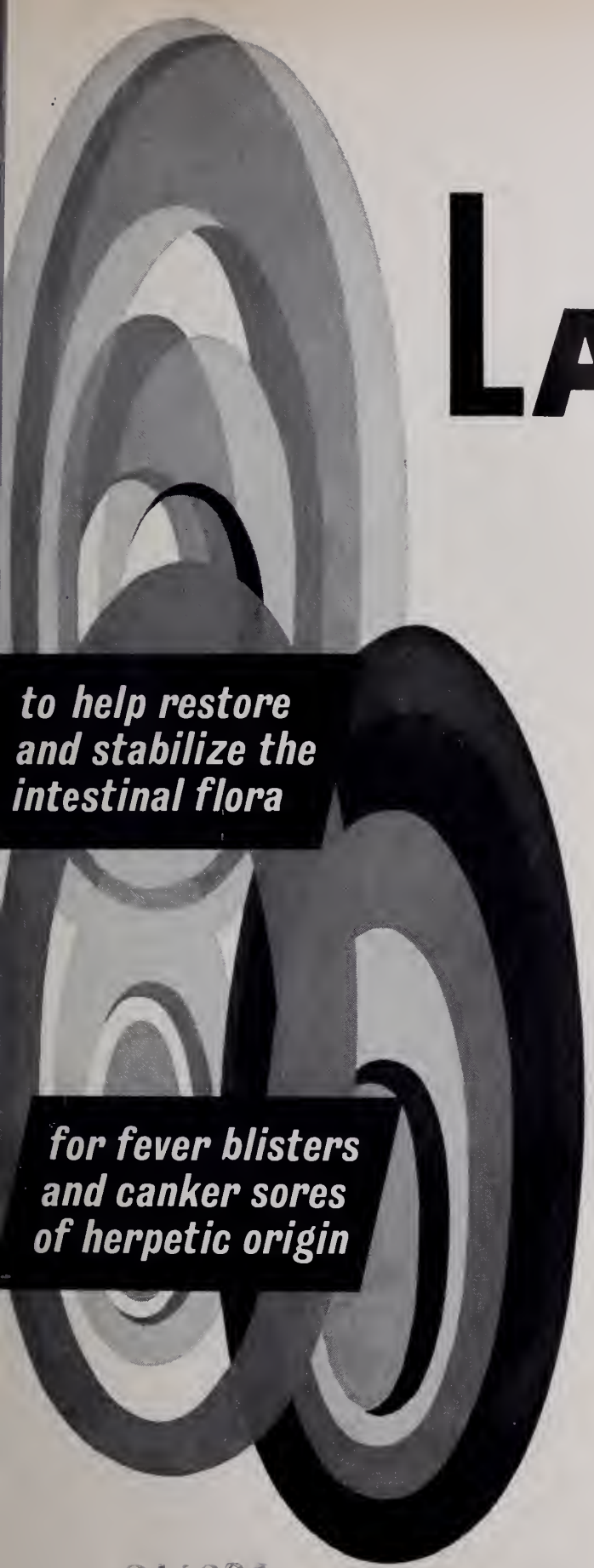
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KMA 1966 Interim Meeting — April 13 and 14
DuPont Lodge, Cumberland Falls


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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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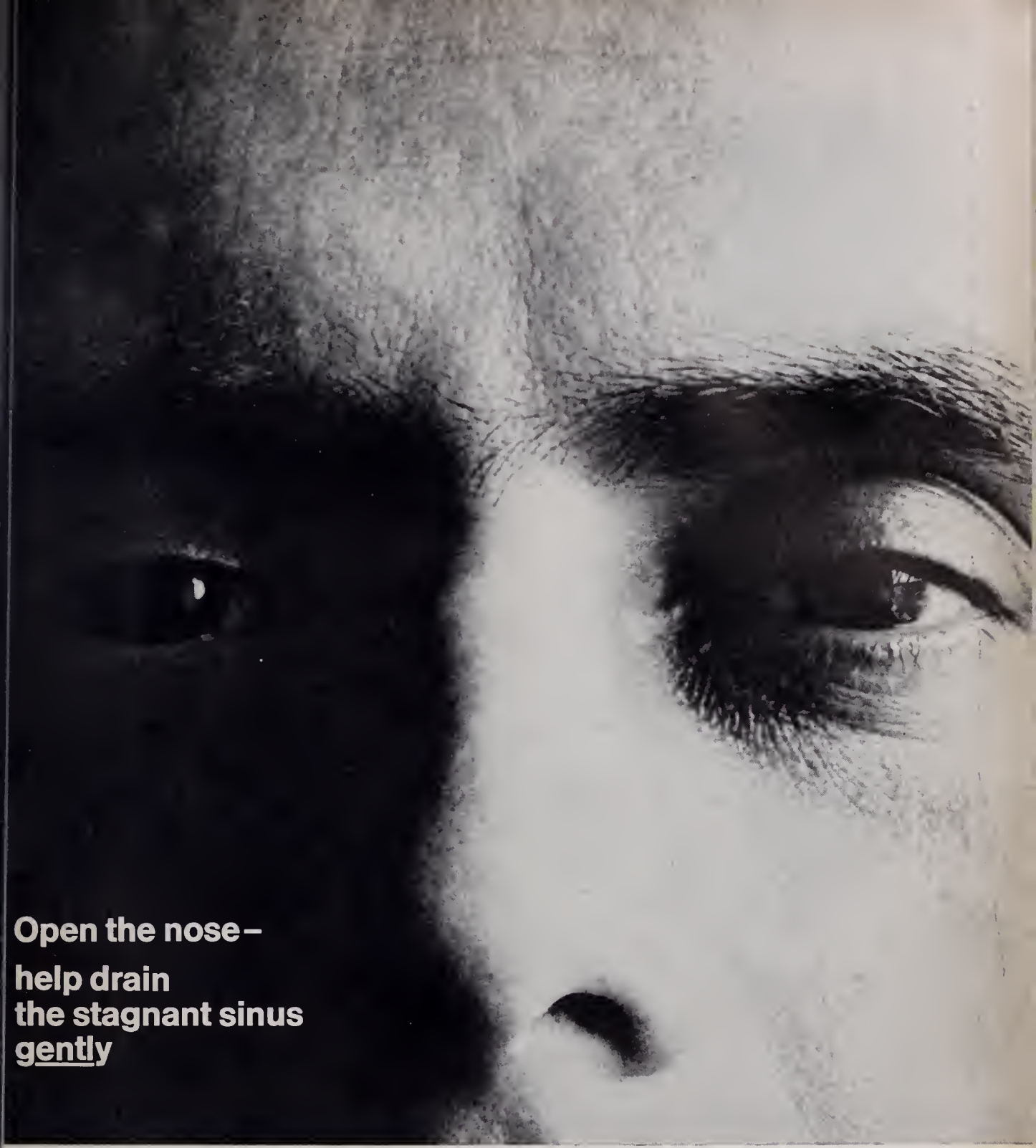
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Neo-Synephrine is a standard among topical vasoconstrictors. It is unsurpassed for reducing nasal turgescence in colds; and a most valuable aid in preventing and treating sinusitis.

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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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MESSAGE FROM THE PRESIDENT



Helping Hands*

RESPONSIBILITY and blessings walk hand in hand. Any person after giving much thought to this must agree. The doctors' wives in this state are being asked this year not only to assume the responsibilities that go along with the unique position they hold in their respective communities, but also to share their many blessings with others less fortunate.

Mrs. Richard Sutter, our AMA Auxiliary president, has asked us to fit our program to our state needs and to work with other state and local organizations in order to help keep Federal government out. With this in mind, I have asked the Auxiliary, with permission of our advisory committee, to work with the Frontier Nursing Service. This private organization has been combating not only poverty in Eastern Kentucky, but has been improving health standards in this part of our state for the past 41 years.

My request to help this group appears to be heartily accepted. At our Board meeting in November, clothing, layettes, bottles and many other articles were assembled to be sent to Wendover. In addition, sample drugs were brought to be sent to World Medical Relief.

Yes, the Auxiliary to the Kentucky Medical Association is "growing" up and maturing and accepting their responsibilities as good citizens of our state and country. We are not only accepting our responsibilities, but we are sharing our many blessings.

MRS. ROBERT SALISBURY, PRESIDENT

WOMEN'S AUXILIARY TO THE KMA

**This is the first in a series of guest articles written at the request of KMA president Everett H. Baker, M.D., by the president of the Woman's Auxiliary and the three KMA vice-presidents.*

Announcing
EUTRON™

pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



Each Eutron tablet contains two proven antihypertensives in the ratio shown to be most effective in most patients.

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New **EUTRON** extends your range of treatment in moderate to severe hypertension



A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

512214



THE INSURANCE PAGE



Physicians' Fees

THE AMA House of Delegates, meeting in Philadelphia in November, 1965, heard extensive discussion and debate regarding the subject of Direct Billing of patients as opposed to the acceptance of assignments for payment by government or other third parties.

The following statements were affirmed as the policy of the AMA regarding the fees charged by physicians for medical services (irrespective of whether paid by the patient, the government, or any other third party):

1. "The intimate relationship between physician and patient is served best without the interposition of any third party carrier, whether in the area of diagnosis and treatment or the payment for these services.

2. "It is the patient's responsibility to deal with third party carriers in the area of financial assistance provided that the physician is at all times mindful of his obligations to the patient under Section 1 of the Principles of Medical Ethics.

3. "The physician-patient relationship is served best when there is advance understanding regarding the payment of fees and the physician bills the patient directly for services rendered. However, the physician is ethically free to choose in each case the manner in which he is to be compensated, based upon the exercise of his independent judgment.

4. "The American Medical Association does not approve of any program which may directly or indirectly promote the charging of excessive fees or which interferes with the physician's right to charge fees commensurate with the services he renders.

5. "The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97, or other third-party plans.

6. "It should be remembered that insurance does not create any new wealth. It merely assists in conservation. Insurance may conserve the ability of an insured person to fulfill his normal financial obligations. It does not enhance his ability to discharge added responsibilities if they are in the form of increased fees. To use insurance as an excuse to revise professional fees upward is but to contribute to the defeat of its purpose. If these indisputable and self-evident facts are not embraced by the entire membership of the profession, then it will have dealt irreparable harm to the whole movement. Also any such failure might give impetus to whatever demand now exists for forcing rigid benefit schedules on the profession.

7. "The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles of Medical Ethics. The physician's fee should be commensurate with the services rendered and the patient's ability to pay.

8. "It is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his particular fee within reasonable limits. In matters relating to fees, the physician should try, to the best of his ability, to insure justice to the patient and himself and respect for his profession."

WILLIAM W. HALL, M.D.

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Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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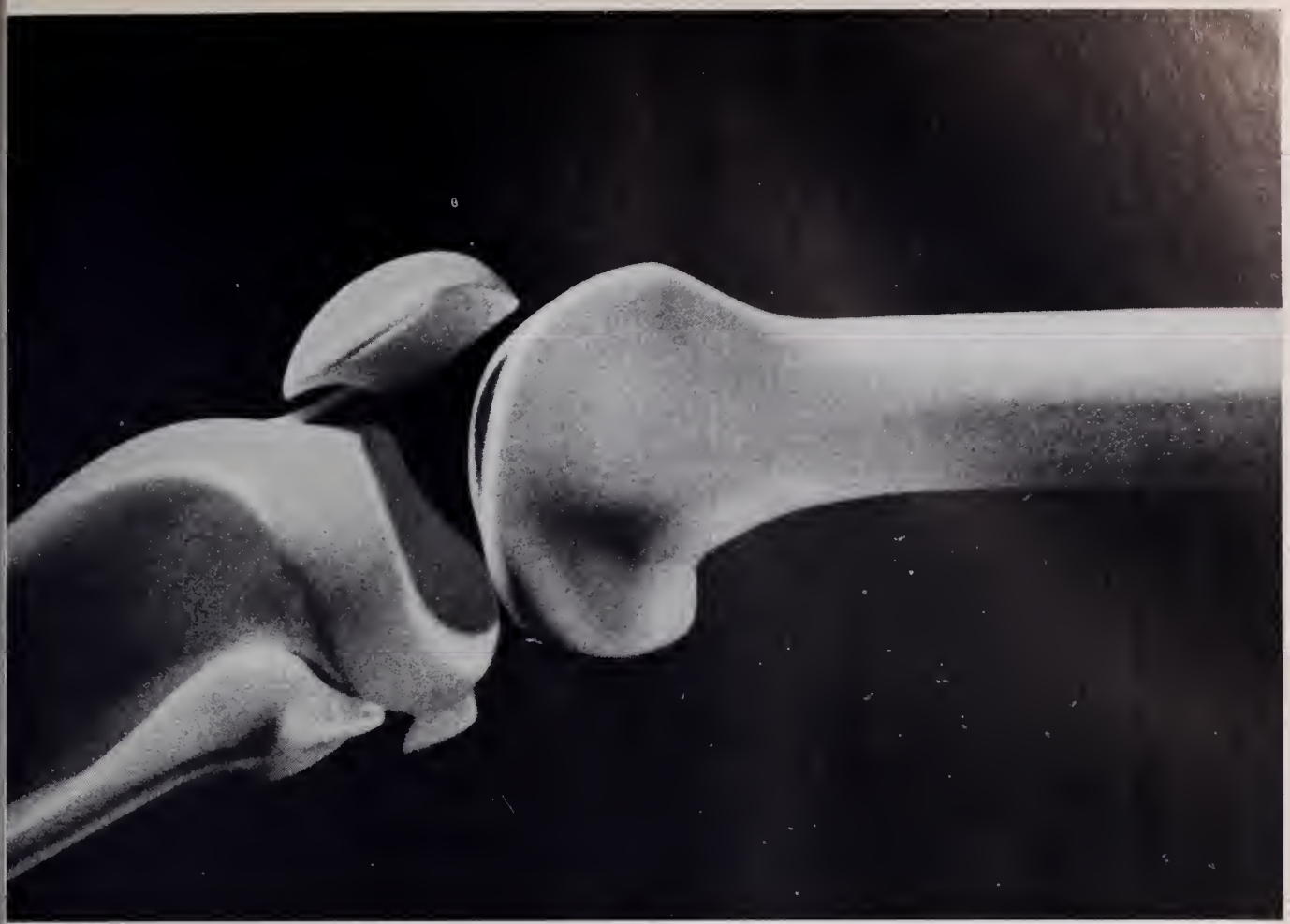
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Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Also available: Butazolidin®,
brand of phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York BU-3804 P

Geigy

PUBLIC HEALTH PAGE

Occupational Disease Report Form For Hospitals

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health, Commonwealth of Kentucky

OCCUPATIONAL DISEASES have existed since man began utilizing nature's resources to equip himself with the tools and materials for providing a better and more comfortable living. Through the years the incidence of occupational diseases has continued to rise, accompanying the industrial growth and development along with the host of new products and methods.

Now in the 20th Century, we have not only the illnesses from contact with chemicals, insecticides, solvents, etc., but such problems as the stresses and strains from automation, the affects from high frequency noise, physiological action, and from highly toxic compounds as well as the hazards of space travel. As occupational health problems evolve from hazards such as these, and numerous others encountered daily, far too many workers are dying, are acutely or chronically ill, or are totally and permanently disabled. This has been due to the absence of preventive medical measures as well as the lack of adequate environmental control measures.

Two means of rectifying this deficiency are to determine when occupational illness has occurred and to determine the hazard which caused the occupational disease. Therefore, reference is made to the Kentucky Occupational Health Regulations based on the Kentucky Revised Statutes, KRS 211.180, which states:

"It shall be the duty of every physician, or when no physician is in attendance, every employer, to report to his local health department or to the State Department of Health within forty-eight hours after discovery, every occurrence of illness, disease or death suspected or known to have been contributed to by conditions of the working environment or activity, except those conditions incident to or resulting from traumatic injuries."

Numerous cases of illnesses requiring hospital care occur every year. Without the cooperation of the hospital administrator, medical records librarian and the physician, even the most serious occupational illnesses go undetected. Quite often the real cause of the problem remains undetected to recur at a later date.

The hospital patient's chart contains vitally needed information of occupational illnesses which is unobtainable elsewhere. Therefore, both as a means for detecting and preventing occupational diseases as well as a method for implementing the Occupational Disease Reporting Regulation, adopted by the State Board of Health in 1956, an occupational disease report form has been designed for hospital patients' charts. The form should be filled out in duplicate, using the interleaf with carbon type paper.

REPORT OF OCCUPATIONAL DISEASE

Hospital: .....

Address: ..... Street City

Present Employer: ..... Name (Please Print)

..... Business Address Street City Stote

Type of Business (Work Done or Goods Made): .....

Worker: ..... Name (Pleose Print) Age Sex Roce

..... Home Address Street City Stote

Employment Dote: .....

Job or Actuol Work Done: .....

Dote of Onset: ..... First Occurrence: Yes.... No....

If Recurrent, Date(s) of Previous Onsets: .....

Clinicol Symptom(s) of Current Illness: .....

Diagnosis of Current Illness: .....

Clinicol Test(s) Performed: .....

Subslonce(s) or Condition(s) Stoted os Cause of Current Illness:

.....

Prognosis: .....

Return Originol To:
Occupational Health Program
Kentucky State Deportment of Health
275 Eost Main Street
Frankfort, Kentucky

.....M.D.
Signed by

.....
Address

.....
Date

The information provided in these reports is used for remedial purposes and is not used for any litigation purposes by the State Department of Health.

(Continued on Page 86)



On Stelazine® brand of trifluoperazine she's calm and alert

When a tranquilizer is needed, 'Stelazine' can regulate the level of anxiety so that the patient is unlikely to overreact to stress but is not tranquilized into psychic inertia. Patients on 'Stelazine' often experience a sense of mental alertness and, because they feel so much better, are more interested in their normal activities.

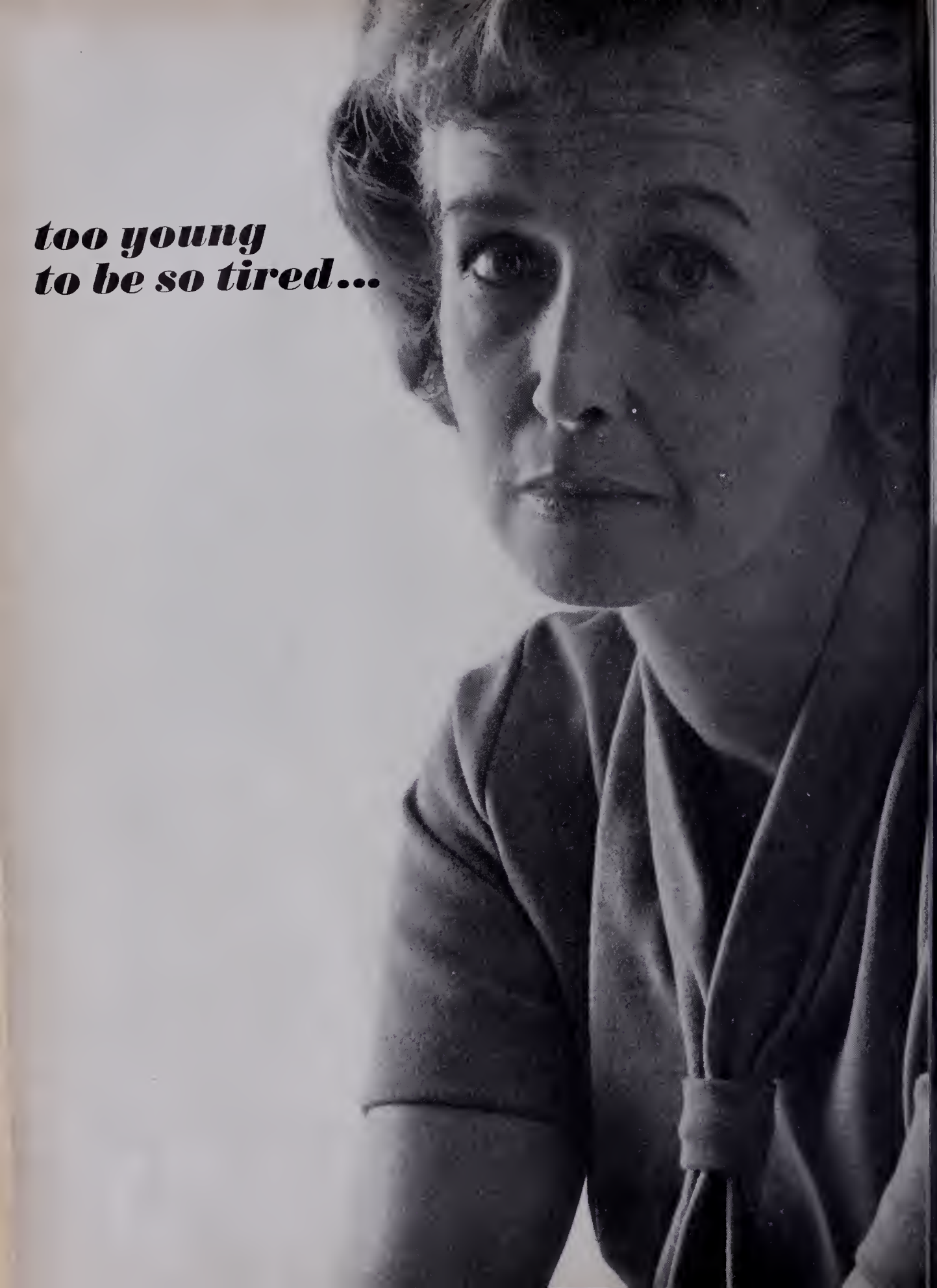
Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

Photograph professionally posed.

SK&F

Smith Kline & French Laboratories


too young
to be so tired...



revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Division of Richardson-Merrell Inc.
Cincinnati, Ohio/Weston, Ontario

Merrell



BRING THE TREATMENT TOGETHER IN A SINGLE PRESCRIPTION

ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

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The discomforts of

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SPASTIC URETERITIS
BLADDER SPASM

. . . are relieved by direct musculotropic action with

Trocinate®

BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

Trocinate *BRAND* THIPHENAMIL HCl

BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

. . . directly relaxes smooth muscle spasm
. . . combats hypermotility
. . . non-mydriatic – may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856


When
tetracycline
is indicated in
these candidates
for Candida...
1.
2.
3.
4.
5.

New low-cost tetracycline/ antifungal therapy

Tetrex®-F

tetracycline phosphate complex –nystatin

Because new Tetrex-F (tetracycline phosphate complex-nystatin) is the most economical therapy of its kind that you can prescribe, it is a sound choice whenever tetracycline therapy is indicated in patients predisposed to monilial infections.

Who are these "candidates for Candida?"

1. diabetic patients
2. nonpregnant women with a history of recent or recurrent monilial vaginitis
3. elderly or debilitated patients
4. patients with a past history of moniliasis
5. patients on long-term tetracycline or corticosteroid therapy.

For these patients, Tetrex-F provides efficient tetracycline therapy against a broad range of infections *plus* protection against superinfection associated with the overgrowth of *C. albicans* in the G.I. tract.

Priced for savings

Tetrex-F is lowest in cost—priced 20% lower than most tetracycline/antifungal products.

BRISTOL THERAPEUTIC SUMMARY
For complete information, consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal, and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms.*
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with Tetrex. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dose: 250 mg. *q.i.d.* Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.
Available: Capsules, tetracycline phosphate complex, 250 mg., and nystatin, 250,000 units.

*In patients with increased susceptibility to monilial infections.

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Syracuse, New York

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ASHEVILLE, NORTH CAROLINA
Affiliated with Duke University





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Contact: Medical Director, Highland Hospital, Asheville, N.C. 28801

MEN'S SHOP



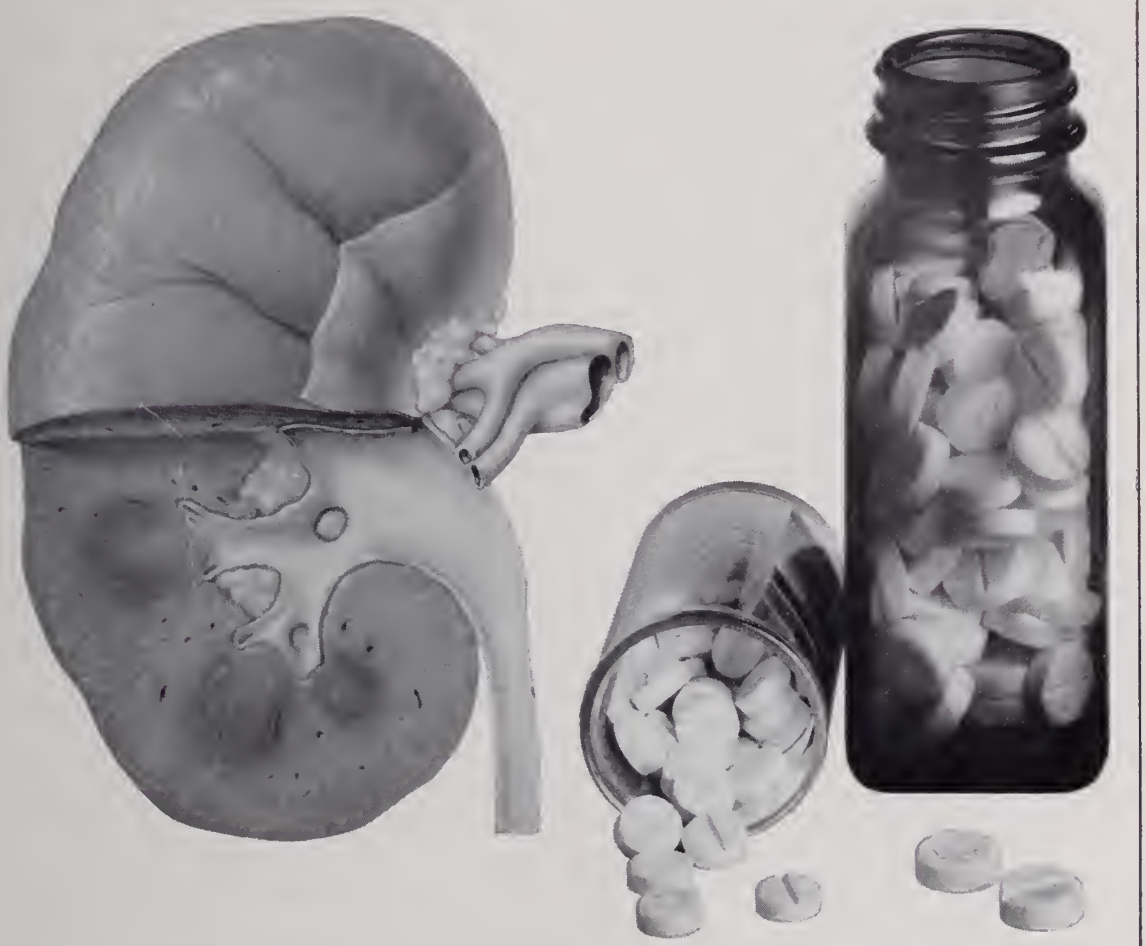
. . . in the **SOUTHERN OPTICAL BUILDING,** 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

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MEDICAL TOWERS BLDG., Floyd & Gray
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Contact Lens and Artificial Eye Service on Opthamologist's Prescription Only

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

JANUARY

13-14 Cardiac Emergency Course, University of Kentucky Medical Center

19 Methodist Evangelical Hospital, Postgraduate Education Day, Louisville

20 KAGP Northern Kentucky Seminar, 9:30 a.m., Holiday Inn Cincinnati South, South Fort Mitchell, Ky.

FEBRUARY

2 Professor's Day, University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

9-10 Pulmonary Physiology for Practicing Physicians. University of Kentucky Medical Center.

16 Obstetrics for General Practitioners. 9:00 a.m.—4:00 p.m., University of Kentucky Medical Center.

MARCH

2 Professor's Day, University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

21 KMA Senior Day, University of Louisville School of Medicine, Rankin Amphitheater

24-26 Fourth Annual Seminar of Department of Pediatrics, University of Kentucky Medical Center

30-31 Kentucky Heart Association, 12th Annual Symposium on Cardiovascular Disease, Brown Hotel, Louisville.

APRIL

5-8 Kentucky Dental Association Annual Meeting, Louisville

6 Professor's Day University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

12 KMA Senior Day, University of Kentucky Medical Center, Lexington

13-14 KENTUCKY MEDICAL ASSOCIATION Interim Meeting, Cumberland Falls

21 Kentucky Thoracic Society Annual Meeting, in conjunction with Kentucky TB & RD Association Meeting, Rankin Amphitheater, Louisville General Hospital

25-28 Kentucky Hospital Association Annual Meeting, Louisville

MAY

2-6 Symposium on Cardiovascular Disease, University of Kentucky Medical Center

4 Professor's Day, University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

10-12 Kentucky Academy of General Practice, Annual Scientific Assembly, Kentucky Hotel, Louisville

13-14 Kentucky Surgical Society Annual Meeting, French Lick Sheraton Hotel, French Lick, Indiana

18-19 Kentucky Pediatric Society Annual Meeting, Owensboro

IN SURROUNDING STATES

JANUARY

19 Vascular Surgery, Postgraduate Course, Cleveland Clinic, Cleveland, O.

20 Biliary and Pancreatic Surgery Course, Cleveland Clinic

22-27 American Academy of Orthopaedic Surgeons, Annual Meeting, Palmer House, Chicago

26-27 Advances in Pediatrics, Cleveland Clinic

28-30 Southern Radiological Conference, Grand Hotel, Point Clear, Alabama

FEBRUARY

1-5 American College of Radiology, Drake Hotel, Chicago

2-3 General Practice Course, Cleveland Clinic

2-6 American College of Cardiology, Conrad Hilton Hotel, Chicago

9-11 American Academy of Occupational Medicine, Bellevue-Stratford Hotel, Philadelphia



The Pain Is Gone

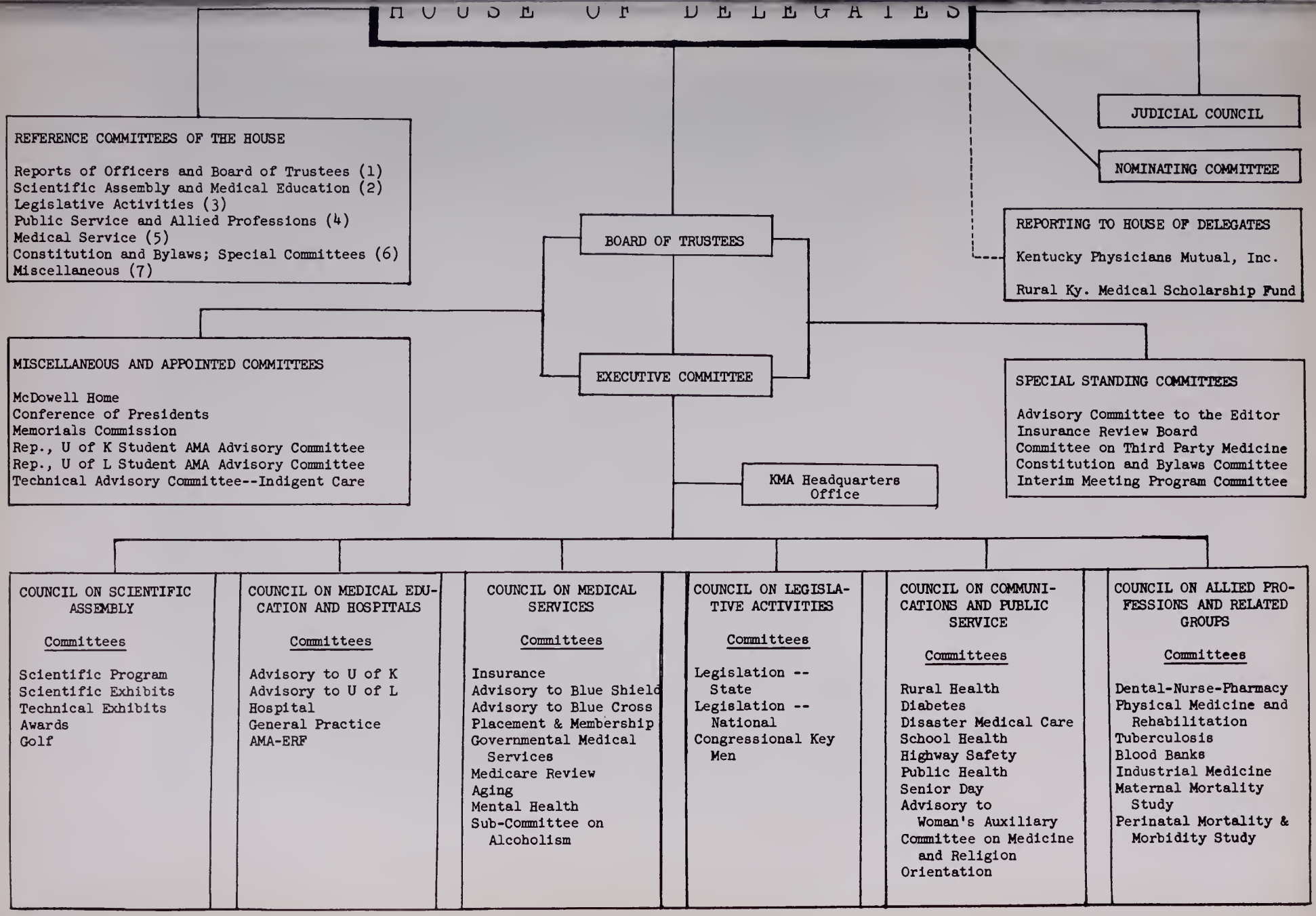
Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

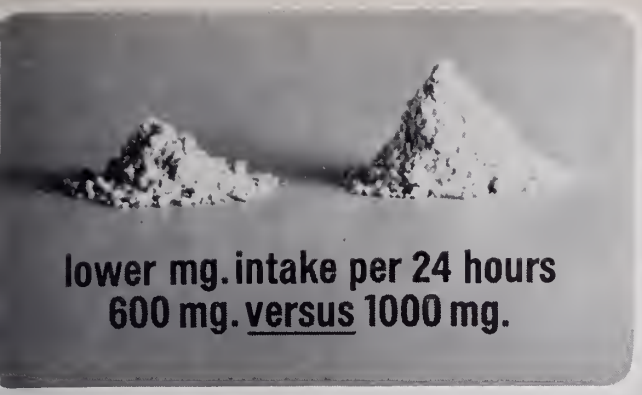
Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief

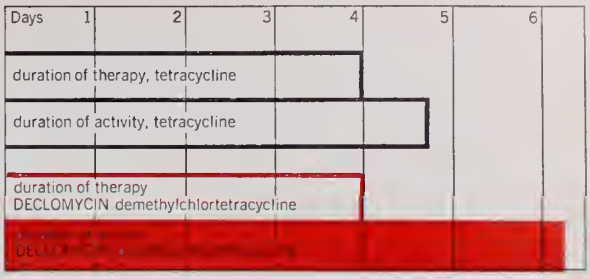
BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



KMA Organization Chart—Revised January 1, 1965

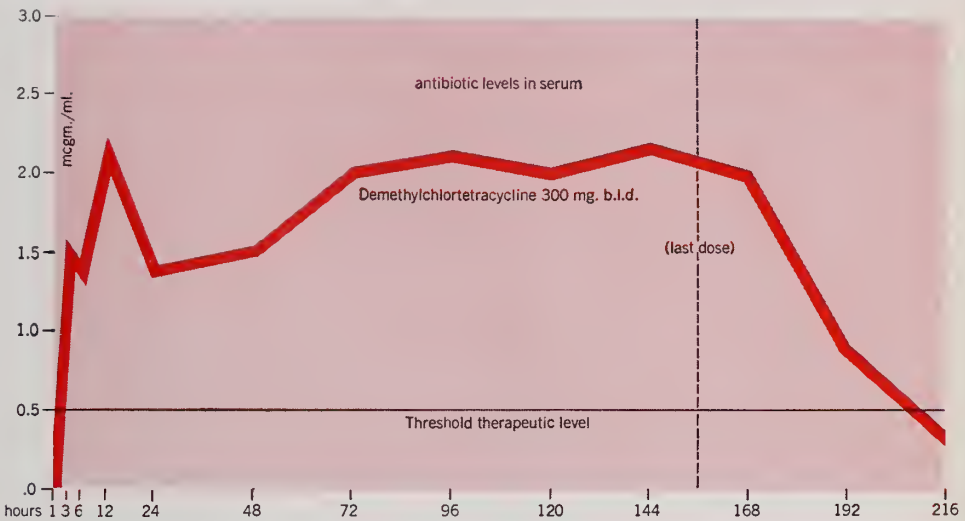


lower mg. intake per 24 hours
600 mg. versus 1000 mg.

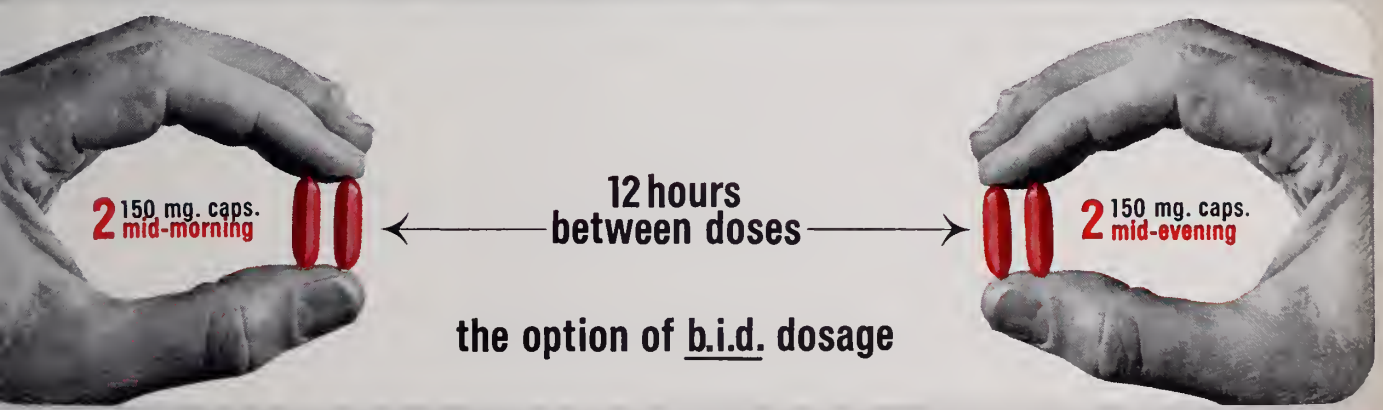


1-2 days' "extra" activity

higher activity levels than other tetracyclines— with less peak-and-valley fluctuation



From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.; Amer. J. Med. Sci. 243:296 (Mar.) 1962



the option of b.i.d. dosage

he "extra" benefits raise the evel of antibiotic control

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE
150 mg. CAPSULES

ffective in a wide range of everyday infections—respiratory, urinary act and others—in the young and aged—the acutely or chroni- ılly ill—when the offending organisms are tetracycline-sensitive. *de effects* typical of tetracyclines include glossitis, stomatitis, pctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nsusceptible organisms, tooth discoloration (if given during pth formation) and increased intracranial pressure (in young fants). Also, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCl.
Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d.

EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
8035-9720

IN THE BOOKS

SYNOPSIS OF CARDIOLOGY: By William I. Gefter, M.D., Bernard H. Pastor, M.D., and Ralph M. Myerson, M.D.; Published by the C. V. Mosby Company, St. Louis, 1965; 839 Pages; Price, $9.85.

Synopses, particularly of large subjects, are falling into increasing disfavor among modern medical educators. Students at all levels are encouraged to consult textbooks, monographs and original papers. This trend decreases the usefulness of this book, although the authors have succeeded in their aim to "summarize the various aspects of cardiovascular disease in a concise and readable form without sacrificing completeness."

The first 247 pages are devoted to cardiovascular examination. A more complete description of the jugular venous pulse would have improved the clinical part of this section. The portions dealing with electrocardiography and roentgenology are very good and excellently illustrated. It is disturbing to find the formula for cardiac output repeatedly expressed such that it yields the result in cc. per minute.

The following two sections are on circulatory failure and on arrhythmias and much useful information is summarized within them. There are several excellent illustrations of arrhythmias.

The fourth section covers etiologic heart disease. The authors are put on their metal to precis this rambling topic. They usually succeed admirably, but the section on congenital heart disease is weak and in several instances erroneous. It is hoped that in subsequent editions this portion will be revised, perhaps with the help of an expert in this sub-specially.

The fifth section is a brief but good summary on peripheral vascular disease. The last section, on "special problems" is excellent, especially the chapters on anticoagulation therapy, surgery, and rehabilitation.

An over-fondness for eponyms pervades the text from Broadbent's sign on page 10 to Monge's disease on page 839. The printing, paper and illustrations are of very high quality. The book is uniformly easy to read and the price is reasonable for the amount of material and the quality of production.

RALPH SHABETAI, M.D.

CURRENT SURGICAL MANAGEMENT, III: edited by Edwin H. Ellison, M.D., Stanley R. Frieson, M.D., and John H. Mulholland, M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1965; 519 Pages; Price, $11.50.

The format of this volume will be familiar to those who have encountered the previous two volumes. Each section is prefaced by a general consensus by one of the three editors, which is well done in each instance. For the most part, the authors are well chosen. What they have to say, and how they say it, is disappointing.

In the preface to the original volume, which is reproduced in Volume III, the editors say, "The notion for the creation of this volume arose out of the inclination of surgeons to argue their differences". Much of this spirit was delightfully preserved in Volumes I and II: it is, alas emasculated throughout most of Volume III. There is too much suave generalization, not enough depth of material, inadequate and biased bibliographic references. This is particularly noticeable in what should be the highly and bitterly controversial section entitled, blandly, "Carcinoma of the Breast". Here, for example, entrusting both sides of the fascinating controversy of early vs late oophorectomy (ineptly labelled "prophylactic and therapeutic") to the Horseleys who have traditionally been always on the side of the first alternative, is intellectually disappointing.

Edgar Poth is an excellant man to discuss surgical correction of dumping, but limits his discussion to his own technics. Both in the text and in his bibliography he ignores the highly significant contributions of many others in this field.

In other fields, it would seem to this reviewer that had the various authors read one another's conflicting viewpoints before final publication, some of the lively spirit of debate might have survived. The only vestiges of this are to be found in Strode vs Farris on gastrostomy vs intubation, Madden vs Hoerr on fundus to porta cholecystectomy and vice versa, and among the various protagonists discussing hernia repair.

The occasional surgeon will find little to absorb and retain, and the sophisticated surgeon will find little stimulation, from this book.

GEORGE B. SANDERS, M.D., F.A.C.S.

PHYSIOLOGIC FOUNDATIONS FOR MARRIAGE COUNSELING: by Joseph B. Trainer, M.D.; Published by the C. V. Mosby Company, St. Louis, 1965; 273 Pages; Price, $8.00.

Adequate counseling of prospective marital partners is one of the most difficult yet challenging obligations of practice. At the same time, such efforts offer the practitioner unique and tangible rewards in facilitating the adjustment of couples embarking on the major undertaking which life affords. Such sensitive information must often be foisted upon recipients too embarrassed to ask for it.

Even in this age of liberal enlightenment, rare is the child who receives sex education either at an age when it will do the most good or in the family, the place where it should be dispensed ideally. Average parents have neither the knowledge nor the vocabulary to do the job. The physician's help is sought years too late. Unfortunately, even he is not always interested

(Continued on Page 86)



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
Cranbury, N.J.

CM-5761



Low host resistance?

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Preoperative Irradiation and Surgery in Head and Neck Cancers†

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It is the general experience of most radiotherapists and surgeons that radiation or surgery alone are insufficient for a five year cure rate. This paper reviews the results in a series of patients who have undergone preoperative irradiation followed by surgery.

DURING the past three decades the two disciplines of therapy in various forms of malignancies of the head and neck, surgery and irradiation, have been in competition with one another. Experience has shown that the prognosis for radical surgery of Stage II and III cancers of the maxillary sinus, tongue, tonsil, hypopharynx and upper esophagus, varies somewhere between 20 and 50% for a five year cure rate. It is the general experience of most radiotherapists and surgeons that radiation alone is not as good as radical surgery. Neither method of treatment is successful enough from a five year cure rate to warrant continuing these methods.

†*Presented at the third general scientific session of the 1965 KMA Annual Meeting held September 21-23 in Louisville.*

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Causes of Failure

Failures of head and neck malignancy management can be attributed to the following factors: (1) Irradiation after radical surgery fails to sterilize the persistent tumors due to tumor and regional tissue avascularity, (2) radical resection for tumor persistence or recrudescence after full course of radiotherapy fails because of tumor repopulation, and (3) surgery in the latter instance is often complicated by loss of skin or prolonged morbidity (time-dose relationship).

The concept of low dose irradiation combined with radical surgery is based on a biologic concept that the incidence of failures due to local or neck recrudescence could be reduced significantly without the added risk of surgical complication. In animal experimental work using a moderately aggressive tumor implanted in mice, we were able to demonstrate significant improvement in survival of such animals by preoperative low dose irradiation and surgery compared to a series with no treatment, low dose irradiation, or surgery alone.

In the animal series, a dose of 500 rads, obviously insufficient to cure the cancer, inactivated 95% of the biologic activity of the cells, and then surgery was 85% successful as compared to 50% when surgery alone was employed, 1% when only irradiation was used and no survivals with no treatment.

Selection of Cases

The criteria for patient selection were rigid. Only those cases considered operable but of guarded prognosis were included (Stage II or III). The prognosis of these cases depended upon this staging together with the grade of the malignancy. If these cancers were in the hypopharynx and larynx, the best suited operation was determined prior to irradiation. If the case was considered highly curable (80% and up) by irradiation alone, it was not included in the series. Nor were cancers highly curable by surgery included. In each instance, the tumor was mapped out by drawing, direct photography and radiographic evaluation (laryngograms), and notation of the nodes was made.

Two to three thousand rads are given over two weeks and the patient operated upon in the third or fourth week. There should be absence of skin reaction or mucositis at the time of operation.

In 250 patients with varying tumors, 55 of which have gone past the two year period, the following observations can be made by comparing these cases with similar lesions treated by surgery alone.

Prior to planned preoperative irradiation, one could expect a 30-40% local recurrence rate either by implants, or the appearance of late metastatic nodes from inapparent occult metastases.

Results

In the series to be reported, this review can only be stated as *trends*. Thus far there is an overall 14% local recurrence rate compared to a 40% recurrence rate without preoperative irradiation therapy. For the larynx, an 8% stomal recurrence rate used to result with certain forms of laryngeal malignancies. Our experiences to date show that in 34 similar laryngeal malignancies there were no stomal recurrences at the two year period. All of the non irradiated malignancies treated by surgery usually had stomal recurrences by two years, prior to the use of pre-operative irradiation.

The use of low dose preoperative x-ray and surgery is not without certain complications. There is a delay in healing by several days, and with each increment of 1000 rads there is a further time delay in healing. Carotid artery blow out with radical neck dissection occurs in an incidence of 2% in our series compared to a 0% incidence without irradiation. In the last 75 cases where the carotid artery has been covered by a scalene muscle flap, the vascular rupture has been nil.

One third of the specimens resected show no evidence of tumor with these low doses. One third show bizarre cellular response with recognizable tumor and one third show minimal persistent tumor. Uniformly the clinical response preceded the histologic regression to irradiation.

Summary

In summary it is apparent that the improvement in short term survival by planned preoperative irradiation and surgery, used in the case when first seen, has yielded certain trends in improvement for tongue, tonsil, sinus, pharynx and larynx lesions without undue increase in the complication rate. In time, we should be able to determine the optimal planned dosage in these cases. We have been able to spare many more larynges previously treated by total removal, and with promising early results.

Hear panel on

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Burn Stress Pseudodiabetes†

GILES L. STEPHENS, M.D.* and MICHAEL R. CRONEN, M.D.**
Louisville, Ky.

A case of burn stress pseudodiabetes is presented. The pathology and treatment are discussed.

THE purpose of this paper is to emphasize the serious nature of the rare syndrome of burn stress pseudodiabetes in order that it will be recognized more promptly and proper treatment expedited. A case is presented which was further complicated by a bleeding Curling ulcer.

Cannon in 1918 observed hyperglycemia following traumatic shock.[5] Howard noted that soldiers wounded in Korea had a diabetic response to the glucose tolerance test and a decreased sensitivity to insulin.[9] Taylor et al. observed a direct relationship between the extent of the burn trauma and the hyperglycemic response.[14] Evans and Butterfield in 1951 described the syndrome of burn stress pseudodiabetes which is manifested by hyperglycemia, glycosuria without acetonuria, acute dehydration, shock, coma, and renal failure.[7] In their cases this syndrome complex appeared prior to the tenth postburn day and was thought to be aggravated by forced feeding. According to Arney the syndrome of burn stress pseudodiabetes may ocur more frequently than is recognized clinically.[1] This clinical entity may escape recognition because of the lack of appreciation of the typical clinical and laboratory features.

Case Report

Mr. E. E. H. — No. 45662. This 60 year old white male retired machine operator, a known epileptic, had a grand mal seizure at 4:30 P.M. on 10-28-64. He fell in a pile of burning leaves and incurred burns of his right hand and both lower extremities. The patient had been off anticonvulsant therapy for approximately one week before this seizure. He was seen on this date in the emergency room of the St. Joseph Infirmary, Louisville; physical examination revealed an estimated total body burn of 26% and an estimated third degree burn of 16%. Occlusive burn dressings were applied by Doctor Cronen and the patient was started on prophylactic penicillin therapy and given tetanus antitoxin. He was immediately placed on anticonvulsant therapy of Dilantin and Phenobarbital. The fluid intake and output were recorded. Morphine was given for relief of pain. The patient was given intravenous fluids and electrolytes to supplement his oral intake. He developed no diminution in urinary output.

On 11-3-64, under general anesthetic, excision of the third degree burns of the anterior aspect of both legs and the anterior right thigh was carried out. The patient received 1000 cc of blood during the operative procedure and tolerated this surgery very well.

On 11-5-64, under general anesthetic excision of split thickness grafts from the skin of the back and excision of some necrotic skin of the anterior aspect of both legs and necrotic right tibialis anterior muscle was performed. These skin grafts were sutured to the skin defects of both legs and the right thigh. The patient tolerated this operation very well.

On 11-12-64 excision of the remaining necrotic skin from the posterior aspect of both legs and the posterior aspect of the right thigh was carried out. Again the patient's postoperative course was uneventful. His hemoglobin on 11-13-64 was 12 gms per cent and the hematocrit was 40 per cent.

On 11-16-64, under general anesthetic again, the patient had excision of necrotic skin of the posterior aspect of the distal third of the right leg and excision of split thickness skin grafts from the anterior chest, abdomen, and back. These skin grafts were sutured to the skin defects of both legs posteriorly and the right thigh posteriorly and the right prepatellar region. In all of the postoperative periods the patient was

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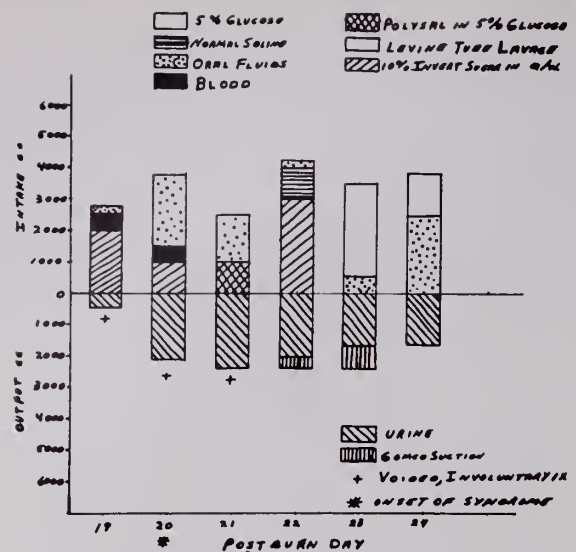


FIG. 1 THE TOTAL FLUID INTAKE IS PLOTTED UP FROM THE ZERO LINE AND THE MEASURED FLUID OUTPUT IS PLOTTED DOWN FROM THE ZERO LINE.

placed on Chloromycetin, aqueous penicillin, and multiple vitamins. He was placed on a regular diet in the postoperative periods, usually by the second postoperative day. There was no attempt to force carbohydrates or proteins.

Following the last operation, the patient developed mental dullness, incoherence, and subsequent delirium at about midnight of the first postoperative day. The patient took oral fluids avidly; however, he developed marked clinical dehydration with the out-pouring of tremendous volumes of urine and exhibited insatiable thirst. In none of the postoperative periods was the urinary output diminished. At this time the clinical impression was that the patient had water intoxication with hyponatremia; however, the serum sodium on the morning of the second postoperative day was 160 mEq/L., potassium 5.6 mEq/L., chloride 120 mEq/L., and the CO^2 19 mEq/L. (See Figure 1). His B.U.N. on this same date was 64 mg% and the hemoglobin 12.4 gm.% with a hematocrit of 40%. In an effort to correct the hypernatremia and hyperchloremia the patient was given intravenous 5% glucose in distilled water. Nasogastric Levine tube was inserted and gastric lavage was carried out, and it was noted at this time that there was "coffee grounds" material as the gastric aspirate. The delirium persisted and deepened into coma.

Fasting blood sugar on the third postoperative day was 254 mg.%, serum sodium was 156 mEq/L., potassium 5.2 mEq/L., and CO^2 20 mEq/L. A second blood glucose determination two hours later was reported as 450 mg.%. The patient was given 50 units of regular insulin intravenously and was given 2 liters of 10% invert sugar in distilled water with 10 units of regular insulin added to each. A repeat blood sugar two hours later was reported as 294 mg.%. A liter of 5% glucose in distilled water with 40 units of regular insulin was then given. In the evening of the third postoperative day the serum sodium was 153 mEq/L., potassium 5.2 mEq/L., chloride 114 mEq/L., CO^2 25 mEq/L., and calcium 8.4 mg.%. The blood pH on this date was 7.44. The delirium was thought at this time to be due to hypernatremia. The patient was running a fever of 101 to 102°F. rectally. It was difficult to explain the hyperglycemia in the face of the urinalysis which showed the urine to be free of acetone. The urine specific gravity was 1.009, albumin ++, sugar ++, pH 5, and the microscopic urine examination was essentially negative except for 9-13 W.B.C. per h.p.f. The B.U.N. on the third postoperative day was 62 mg.%. The patient was placed on a diabetic routine. A slight amount of blood was noted to be coming from the nasogastric Levine tube which was intermittently placed on suction after 200 cc of glucose water was instilled into the stomach in an effort to help correct the hypernatremia and hyperchloremia. (A Cantor tube had been previously inserted, but it failed to pass into the duodenum and it was removed and replaced by a nasogastric Levine tube.)

On the morning of the fourth postoperative day the blood glucose was 161 mg.%, serum sodium 151 mEq/L., potassium 4.7 mEq/L., chloride 103 mEq/L., and CO^2 21 mEq/L. (See Figure 2). The nasogastric Levine tube was removed on the morning of the fourth postoperative day. During the period of coma an indwelling Foley catheter with bedside bottle drainage was used. Urine examinations for sugar and acetone were done on the ward q.i.d. and these examinations were constantly negative for acetone. They were consistently negative for sugar except for one time on the third postoperative day, and on the thirteenth postoperative day, and again on the fourteenth postoperative day. The patient was thought to be mentally more alert on the fourth postoperative day. He was placed on a diabetic 1500 calorie diet of 150 gms of carbohydrates, 70

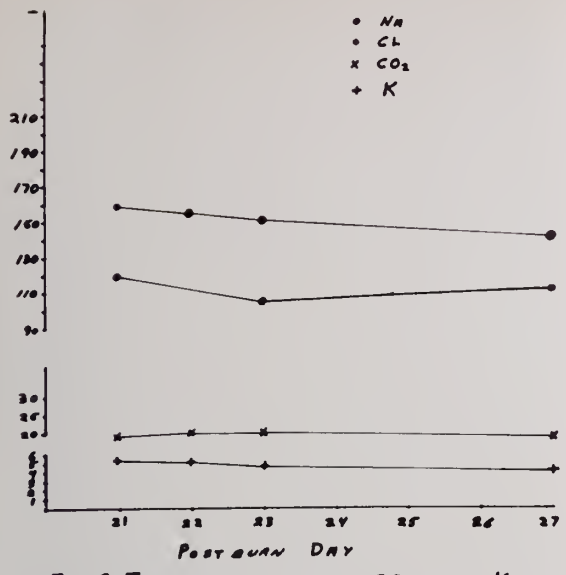


Fig. 2 The serum Na, Cl, CO_2, and K determinations are plotted and show the relationship of the changes observed.

gms of proteins, and 60 gms of fat. His oral intake was supplemented with intravenous 10% invert sugar in distilled water with 10 units of regular insulin added to each liter.

On the fifth postoperative day a pseudomonas infection of the donor's site skin graft wounds of the back was detected; this was treated with topical application of 1% acetic acid in saline dressings with frequent changes. His blood glucose levels on the 5th, 6th and 7th postoperative days were within normal limits. On the tenth postoperative day the patient was noted to have melena. He had no hematemesis and a stat blood count revealed a hemoglobin of 9.5 gms.% with a hematocrit of 31%. His pulse was 100 and the blood pressure was 150/66. He did not complain of abdominal pain at this time and no tenderness of the abdomen was detected. He was placed on Maalox liquid with Probanthine tablets by mouth and was given multiple blood transfusions. Four days later the stools were brown, and six days later his hemoglobin was 13.4 gms.% with a hematocrit of 43%. The patient exhibited no further evidence of gastrointestinal bleeding. His condition improved markedly.

On 12-10-64 under general anesthetic excision of dead skin from the anterior aspect of the right ankle, excision of split thickness skin grafts from the skin of the back and suture of the skin grafts to the skin defects of the right thigh, right ankle, and left pretibial regions were carried out. After the last operation the patient's postoperative course was relatively uneventful. He did not present additional episodes of gastrointestinal bleeding or coma. The patient was continued in the last postoperative period on antacid and antispasmodic. The patient was subsequently ambulated with a walker. He was discharged from the hospital on 12-19-64 at which time he was still on his diabetic diet but was not requiring any insulin. He was started on a regular diet on 11-29-64. A three hour postprandial blood sugar on 11-30-64 was 148 mgs.%. The following day his diabetic diet was resumed. No further insulin has been given. An oral glucose tolerance test on 2-12-65 revealed a diabetic type curve and an oral glucose tolerance test following forced carbohydrate feedings on 2-25-65 revealed an abnormal glucose tolerance curve. (See Figure 3). No family history of diabetes could be elicited from the patient or his sister.

Discussion

In 1951 Evans and Butterfield studied the stress response in patients with severe thermal burns.[7] They noted that the eosinophil count became markedly depressed immediately after burn trauma; they assumed this to be due to intense adrenocortical activity with the release of glucocorticoids. These authors soon learned that the degree of stress could be very conveniently measured by daily eosinophil counts. Burns of large extent had a prolonged depression of the eosinophil count reaching "normal" values of 80 to 200 per cubic mm after four to six days. In superficial small burns the eosinophil count was promptly depressed but it rose

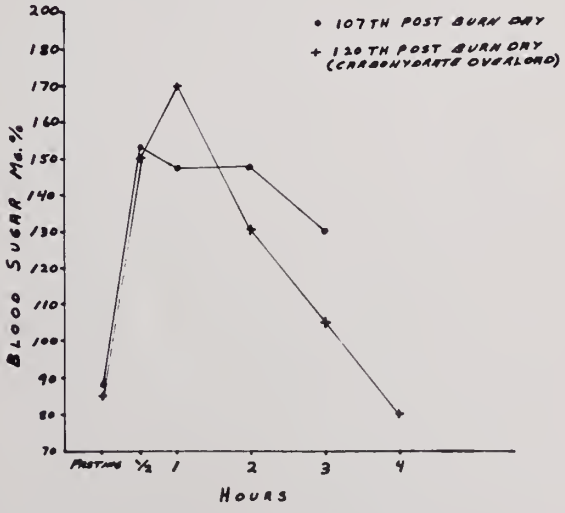


Fig. 3 Oral glucose tolerance tests

sharply after two or three days and reached high normal values (400 to 600 per cubic mm) by the end of the seventh day.

In studying wounded soldiers in Korea, Howard demonstrated that with the metabolic response to injury the oral glucose tolerance curve became diabetic in type and the insulin tolerance curve demonstrated a flattening in its pattern.[9] Both the glucose tolerance and the resistance to insulin appeared directly proportional to the magnitude of injury. Howard further demonstrated that both of these abnormalities diminished as convalescence progressed. In the presence of infection, however, this resistance to insulin persisted for a longer period of time. In 1956 Conn and Fajans stated that the administration of cortisone or ACTH to patients with diabetes usually produced an intensification of their diabetic state.[6] These authors believe that corticosteroids accelerate gluconeogenesis from fat as well as proteins. Adrenal steroids elicit a temporary diabetic state much more commonly in non-diabetic relatives of diabetics than in individuals without a family history of diabetes. In their study to unmask the potential diabetic who manifests normal carbohydrate tolerance by present testing methods they employed a cortisone modified glucose tolerance test to bring to the surface a subclinical defect of carbohydrate metabolism. They found that 24% of presently non-diabetic relatives of diabetic patients responded to this test in a specific way while this same response was observed in only three per cent of people without a known family history of diabetes. Artz believes that these patients with burn stress pseudodiabetes are border-line diabetics and that the burn stress pushes them over into a diabetic state.[4] Artz also believes that forced feeding adds to the problem of the diabetes.

Moyer has described the protein overload syndrome of uremia, hypernatremia, hyperchloremia, hyperpyrexia, and disorientation as a fatal complication of forced tube feeding of a high protein diet to the patient with a thermal burn.[12] The serum sodium concentration may be as high as 170 mEq/L. Artz states that hypernatremia often occurs in the presence of intracellular dehydration and he recommends the giving of large quantities of electrolyte free water to meet the water requirements of the severely burned patient.[13] Artz further states that the plasma sodium concentration is a good index of the adequacy of tissue hydration.

Evans and Butterfield reported three cases of burn stress pseudodiabetes.[7] Two of their patients became delirious on the seventh postburn day and the third patient on the third postburn day. Two of their patients went into shock; this was secondary to dehydration and was followed by renal failure, electrolyte imbalance, and death. The two patients reported by Arney et al. became disoriented on the ninth postburn day and on the eighteenth postburn day.[1] Arney thought that this condition was aggravated by forced high caloric feedings. One of these two patients died of septicemia. The other patient survived and an oral glucose tolerance test performed on the fifty-sixth postburn day showed a typical diabetic response and an intravenous glucose tolerance test performed on the fifty-seventh postburn day showed a normal response. A repeated oral glucose tolerance test performed on the sixty-eighth postburn day showed a normal response. Arney believes that the onset of the delirium in his two patients was directly related to the timing of the forced high caloric feeding regime employed. Arney et al. have observed eight other burn patients with hyperglycemia and glycosuria all of whom were receiving more than 5000 calories per day. Five of the eight patients had a family history of diabetes; four of these five developed clinical dehydration. This was corrected by decreasing the caloric intake and continuing water ad libitum. Six of these eight burn patients survived and none had a demonstrable carbohydrate intolerance subsequent to the healing of their thermal burns. The hyperglycemia depends on either the overproduction of or the under-utilization of glucose in persons who are force-fed. Both the exogenous supply and the decreased tissue utilization of glucose can be responsible for the hyperglycemia. This hyperglycemia can be aggravated by the continued endogenous overproduction of glucose. Arney believes that gluconeogenesis from protein is not sufficient in induced steroid diabetes to account for the loss of carbohydrate tolerance. The severe dehydration in this syndrome is due to the intense glycosuria in osmotic diuresis and Arney states that this is secondary to hyperglycemia, but it should be noted that glucocorticoids may cause a glycosuria due to decreased tubular reabsorption of glucose. The clinical and laboratory

manifestations of this syndrome are in the order of their appearance: hyperglycemia, glycosuria without acetonuria, high urinary specific gravity, and an intense osmotic diuresis.[1] This results in a very severe dehydration with elevation of the non-protein nitrogen, hemoglobin, hematocrit, serum sodium, and chloride levels. Arney stresses that a marked increase in the urinary output is the most striking early clinical manifestation. This syndrome has been seen most frequently in patients who had a family history of diabetes. We believe that the added stress of a pseudomonas infection precipitated the syndrome of burn stress pseudodiabetes in our patient on the twentieth postburn day. The fact that our patient very shortly thereafter developed evidence of a bleeding Curling's ulcer is further evidence that the patient was undergoing a more severe stress reaction at this time.

Evans and Butterfield state that since they first recognized this syndrome they have taken exceeding pains to detect it and have found the syndrome much more frequently than could be accounted for by the pure chance of admission of early unrecognized diabetics. They state that the condition has been more prevalent in older patients and these authors urge that these findings serve as a caution against forced feedings especially in elderly burn patients.

Since 1960, Arney at the Brooke Army Medical Center, observed three additional patients in whom hyperglycemia and glycosuria occurred to the extent of initiating an osmotic diuresis. In each case high caloric feedings were being given. The situation was corrected in each case by merely decreasing the caloric intake. Two of these patients had a family history of diabetes. During the past three years forced feedings have not been employed and this syndrome has not been recognized during this time period.

In a study of 885 burn patients from the Brooke Army Medical Center Moncrief concluded that it is not unreasonable to quote a figure of 25% or greater as a probable incidence of acute ulceration of the gastrointestinal tract occurring in conjunction with major thermal injury.[10] In their series of 103 patients the onset of acute ulceration had a peak incidence concentrated in the first postburn week and in their series 58% occurred during this period. Almost 40% of their 103 patients with Curling's ulcer had minimal symptoms. In their series 68.3% had multiple ulcerations. Gastric lesions appeared with greater frequency in this series than did duodenal lesions. The duodenal lesions were characteristically single ulcerations. Twenty-five per cent of the cases had gastric and duodenal involvement and in every instance the lesions were multiple in both locations. While exsanguinating hemorrhage was most frequent in the case of duodenal ulcerations it was not unusual for massive hemorrhage to occur from a deep punched-out gastric ulcer. The authors stated that it was their clinical impression that there was a high incidence of concomitant occurrence of burn sepsis and acute gastrointestinal ulcerations. However, this was not definitely proved by this study. The initial experience with gastrectomy for bleeding Curling's ulcer at the Brooke Army Medical Center was very discouraging.[3] These patients failed to heal their anastomotic and abdominal wounds. Subsequent cases, studied by Moncrief, have healed their anastomotic suture lines and abdominal wounds per primum.[11] In Arney's series of 103 Curling's ulcer there were seven perforations, six of which were duodenal and one was gastric.

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Lymphography: A Review†

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Lymphography has assumed an increasingly important role in the diagnostic armamentarium available to the physician. The technique of the examination and the needed pressure injection equipment are briefly described. Its clinical application is discussed.

ALTHOUGH arteriography and venography have established their values in clinical medicine, it is interesting that radiographic demonstration of the lymphatic system as we use it today was introduced as late as 1954 by Kinmonth and Taylor.[1,2] There not only has been considerable improvement in the methods of injection, but a much wider application in the various clinical disciplines also has been achieved over the past decade. With the usual precautions of asepsis, controlled injection timing, and limitation of contrast dosage, the procedure has proved to be safe with very few complications.

Methods and Materials

No special preparation or premedication has been found to be necessary; however, in uncooperative and restless patients it is advisable to give 100 mgms. Seconal one half hour before the procedure. Many of our patients are examined on an outpatient basis.

Visual identification of the lymphatics is made by the injection of 0.5 ml. Evans Blue dye (0.5% aqueous solution) intradermally into the medial one or two web spaces of the extremity (hands or feet) when demonstration is desired. Other workers have advocated the use of Patent Blue Violet 10% aqueous solution[3] or FDC Blue #1 or Brilliant Blue.[4, 5] We have found Evans Blue dye to be satisfactory. The aqueous solution of this dye is readily available in any hospital pharmacy.



FIGURE 1. (a) shows the gravity pressure injector with weights in place over the plunger. The four vertical metallic bars around the periphery prevent the heavy weights from falling. (b) shows the pulse type pressure injector in use. The limiting switch on the side of the box (S) controls the amount of contrast to be given. Variable switches in the rear of machine independently control the injection rate of the two syringes.

Under aseptic technique and local anesthesia, a cut down is made over the middorsum of the hands or feet. A lymph vessel (usually several are visible) is identified, secured, and isolated from the surrounding structures. Use of a dissecting microscope is helpful but not essential. A 27 or 30 gauge lymphangiogram needle† is inserted into the lymph channel. Successful cannulation is indicated by an immediate reflux of the blue dye into the lymphangiogram needle and catheter. We have found the needle insertion can be made with ease when maximum distention of the lymph channel is attained by proximal occulsion for one or two minutes. To counteract spasm a small amount of local anesthetic is injected into the lymph vessel initially. The needle is then held in place by 5-0 black silk sutures. Approximately 10 ml. of Ethiodol†† or Ethiodol Chlorophyll†† are introduced by means of a positive pressure injector. Ethiodol, an ethyl ester of poppy seed oil, is favored as it enjoys

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†*Available from Becton Dickinson Company, Rutherford, New Jersey.*

††*Available from E. Fougera & Co., Inc., Hicksville, New York.*

the advantages of blandness, low viscosity, and good contrast density.

A variety of pressure injectors is available commercially. We have used a gravity injector with metallic weights (approximately 10 lbs.) suitably placed over the plunger of a 20 ml. springe (Figure 1a). The speed of injection can be varied by varying the weight over the plunger. In addition, we also have used a positive pressure pulse type injector (Figure 1b), which can deliver the contrast material at a constant speed irrespective of the viscosity of the contrast medium. Both injectors operate satisfactorily. The latter provides an accurately controlled and constant rate of flow—a feature much to be desired. Both instruments were designed and constructed by the technical staff of our department at nominal cost. The injection rate as recommended by Kinmonth et al[3] and Wallace et al[6] is between 6-7 ml. Ethiodol per hour. We have utilized an injection rate of 10 ml. Ethiodol per hour without any ill effects.

A film is taken at the commencement of the injection to detect possible extravasation of the contrast medium. Another film is taken immediately following the conclusion of the injection. The latter film (Figure 2a) demonstrates the lymph channels optimally, showing any gross displacement or obstruction. A 24 hour delayed film (Figure 2b) is taken to delineate the lymph nodes.

At the completion of the examination the skin is closed with interrupted black silk sutures after thorough irrigation of the wound with saline.

The Normal Lymphogram

The normal lymphatics are fine channels approximately 1 mm. or less in diameter. The ramifications pursue a regular course, sometimes branching proximally instead of distally. Unlike veins and arteries, their caliber remains fairly uniform throughout. The valves are placed at a much shorter interval than in the veins. They appear to be more numerous near a lymph node. As a general rule, the superficial lymphatics follow the veins and the deep lymphatics follow the arteries.

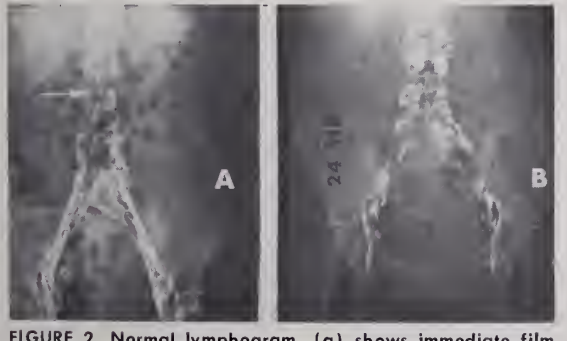


FIGURE 2. Normal lymphogram. (a) shows immediate film following contrast injection. Note thoracic duct beginning at L 2 level (arrow). (b) shows 24 hour delay film. Note the size and shape of the normal lymph nodes.

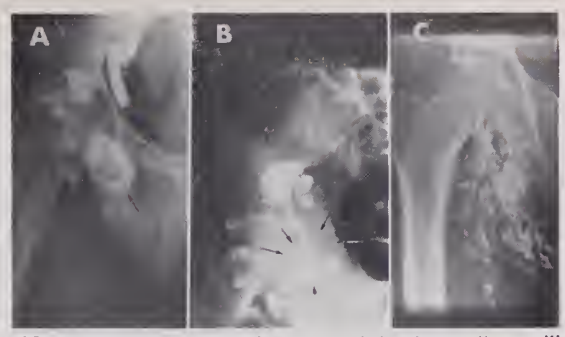


FIGURE 3. Metastatic malignancy. (a) shows "central" type of secondary metastasis to inguinal node from carcinoma of the penis. (b) shows almost total replacement of external iliac node secondary to carcinoma of the urinary bladder. Note only the remaining rim of an enlarged lymph node is depicted by the arrows. (c) shows complete obstruction to the lymph channels resulting from advanced carcinoma of the cervix.

The normal lymph node varies from 0.5 to 2.0 cms. in size. It may be ovoid or kidney shaped. Normal notching of the hilum of a lymph node may be misinterpreted as a filling defect. Such notching is believed to be due to continuous lymph flow in this region, thereby carrying away the contrast medium which has not been phagocytosed by the macrophages or retained within the sinus meshwork.[7] The opaque medium is retained in the lymph node and gradually taken up by the macrophages. Radiopacification persists as long as four to six months following a lymphogram study.

The inguinal lymph nodes and oftentimes the axillary lymph nodes are commonly the site of nonspecific infection and are therefore frequently enlarged.

Clinical Application

1. *Diagnosis of Metastatic Malignancy.* The metastatic node is usually enlarged. The enlargement is variable, and never to the same proportions as that seen in lymphoma. The lymph node also tends to assume a more rounded configuration in contrast to the normal bean or kidney shape. Irregular filling defects within the lymph node are seen. The defects may be central (Figure 3a) or peripheral in distribution. If replacement by metastases is



FIGURE 4. The typical foamy appearance of the enlarged lymph nodes of lymphosarcoma is demonstrated. Note preservation of the rim or margin of all the nodes. Inset shows the right external iliac lymphatic chain of the same patient immediately following injection.

extensive, only the rim of a lymph node is seen (Figure 3b). When the lymph node is totally replaced by metastases, nonvisualization occurs, and this may be the prominent and significant finding. The adjacent lymph nodes in such an instance are probably involved. Obstruction to the lymph flow (Figure 3c) is also a feature of advanced disease. An understanding of the normal anatomical distribution of the lymphatic chain is essential to accurate interpretation.

2. *Diagnosis of Lymphoma.* In Hodgkins' disease, lymphoma, lymphosarcoma, and lymphatic leukemia, a specific pattern in the lymph nodes can be demonstrated. This pattern has variously been described as motheaten, lacelike, or foamy (Figure 4). The lymph nodes are enlarged. The enlargement may be very conspicuous, sometimes attaining gigantic proportions (Figure 4 inset). The margin or outline of the lymph node is preserved. Inferior vena cavography has often shown encroachment of the inferior vena cava by the enlarged nodes.[8] Combination lymphography and inferior vena cavography should be done when feasible, although Mahaffy[9] and Baum et al[10] have shown lymphography to be a more accurate diagnostic procedure for lymphoma.

Dolan[11] attempted to correlate the radiographic appearance with the histological diagnosis. It appears that no definite relationship can be established. We feel that there is some resemblance in the radiographic appearance between a less malignant condition as Hodgkins' Disease in an advanced stage and a more progressive condition as lymphosarcoma in an early stage.

3. *Investigation of Lymphedema.* The study of primary lymphedema has been well documented by Kinmonth et al[12] in 107 patients whose lower limbs were affected. Four main groups were presented in this series.

(1) Aplasia. No lymph vessels were found.
(2) Hypoplasia. There was a definite decrease in the number of lymph vessels as compared to the normal.
(3) Varicose lymph vessels. The lymphatics were dilated and tortuous.
(4) Dermal backflow. The dominant finding was the presence of contrast medium in the small cutaneous lymph vessels.

Jacobsson and Johansson[13] in a smaller series of 22 cases concurred with Kinmonth's findings.

In secondary edema, dilated vessels with local areas of dermal backflow are observed. There is usually no reduction in the number of lymph channels.

4. *Use in Radiation Therapy.* The lymphogram helps immeasurably in accurately localizing the radiation beam. This knowledge is particularly important in seminomas, Hodgkins' disease and lymphosarcoma, in which treatment of the lymphatic system is the radiotherapist's main concern. The lymphogram also offers the additional advantage of following any regression or progression in the size of the lymph nodes.

In carcinoma of the uterine cervix, when intracavitary radium or cobalt has been inserted, the physicist can compute radiation dosage to the pelvic lymph nodes as well as for the conventional points A and B. The latter are, in essence, fixed arbitrary points, whereas the former vary from patient to patient.

Injection of radioactive material into the lymphatics for therapeutic purposes has also been investigated. The advantages include selectivity of irradiation (to the lymphatics) and elimination of skin tolerance as a limiting

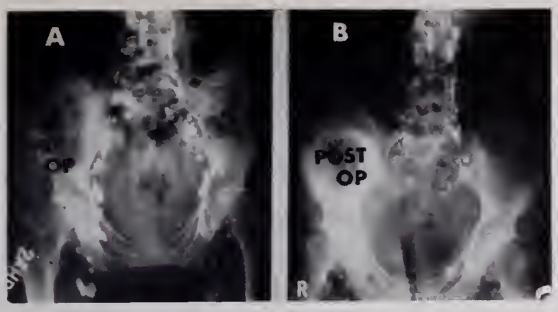


FIGURE 5. (a) shows preoperative lymphogram of a patient with carcinoma of the cervix. (b) shows postoperative film following a pelvic exenteration procedure. Note the lymph nodes in the pelvis have been effectively cleared.

factor. Jantet,[14] however, showed that radioactive colloidal gold, when administered intralymphatically, localized only in normal lymph nodes. The portions of lymph nodes that are replaced by metastases showed no appreciable uptake of the radioactive material. On the basis of this finding, prophylactic irradiation, before metastases can be clinically detected, was suggested.

Seitzman et al[15] on the other hand, obtained encouraging results from the use of radioactive I-131 Ethiodol. Uniform activity to the retroperitoneal nodes was obtained. Moreover, the authors demonstrated no significant uptake by the thyroid, no effect on the hemopoetic system and renal excretion of iodine and iodides in very small amounts. More recently Ariel and Resnick[16] reported beneficial clinical results following intralymphatic administration of radioactive isotopes to lymphomas. Their experiences with chemotherapeutic agents administered in the same manner were not as rewarding.

5. *Postoperative Evaluation.* In radical procedures, the completeness of lymph node eradication can be determined by a postoperative film when preoperative lymphography has been performed, as illustrated in Figure 5. Averette et al[18] used a chlorophyll-Ethiodol combination for intralymphatic injection. He demonstrated a green staining of the pelvic nodes at operation, thereby facilitating dissection and identification of these nodes. Kavazarakis et al[17] have alluded to the fact that a premastectomy lymphogram can provide valuable information as to the number and distribution of the axillary nodes.

6. *Miscellaneous.* Numerous other clinical applications have been described. Gould[19] recommended lymphography in the study of fever of unknown origin to evaluate retroperitoneal lymph nodes. Others have utilized the procedure in the investigation of retroperitoneal fibrosis,[20] ventriculothoracic duct shunts,[21] postmastectomy lymphedema,[22] thoracic duct laceration,[23] chyuria,[24] and chylous ascites.[25]

Complications

1. *Febrile reactions.* Occasionally a low grade fever occurs at a variable interval after the procedure and subsides in 24 to 48 hours without specific treatment.

2. *Wound infections.* Aseptic precautions usually preclude this complication. Since the procedure is generally performed on patients with some form of malignant condition, wound healing may be delayed.

3. *Pulmonary complications.* Clinical pulmonary infarction following the procedure is rare. Fine, microscopic opacities in the lung fields, in otherwise asymptomatic patients, as noted by Gough et al,[26] are not infrequent. Koehler[27] demonstrated "spill-over" of the contrast in a study on dogs utilizing radioactive I-131 tagged Ethiodol. The asymptomatic lung changes probably result from such "spill-overs."

4. *Allergy, overdosage and tumor spread.* Allergic reactions can occur, but this is a very infrequent finding.

One death from overdosage has been recorded in French literature by Desprez-Curely et al.[28] This occurred in a child weighing 30 kilograms in whom 25 ml. of Ultrafluid Lipiodol had been injected four days previously. The same authors[29] six months later reported another case, in which the patient collapsed (with signs of hemiplegia) and died following lymphography. The authors felt this second death probably resulted from the patient's very poor general condition and not from the lymphography. In experimental studies, Kinmonth et al[3] found that a dosage of oily medium greater than 1 ml./kg. is very likely to prove fatal in rabbits, owing to fat embolization of the pulmonary arteries.

The question has often been raised as to the possibility of tumor embolization following pressure injection into lymphatics already involved by carcinoma. The work of Schaffer et al[5] has shown no significant increase in the number of circulating tumor cells following


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Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

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SEARLE

Research in the Service of Medicine



FIGURE 6. Venolymphatic communication. (V) denotes the vein and (L) denotes the lymphatic channel. There was no extravasation of contrast into the soft tissues.

lymphography on metastatic nodes in rabbits.

Earlier reports by Fuchs, et al[30] indicated adverse effects from the introduction of oily media into the lymphatics. More recently, Jing et al,[31] Dolan,[11] Wilder,[22] Wallace et al,[6] and Kinmonth et al,[12] basing their experiences on 421, 200, 150, 110, and 107 cases respectively, have demonstrated that the complications encountered in lymphography are both infrequent and minor in nature.

Limitations of the Procedure

1. Partial immobilization of the patient for a duration of one or more hours is required.

2. Visualization of mediastinal and mesenteric lymphatics has not as yet been possible. To date, demonstration of the lymphatics has been restricted to the axillary, supraclavicular, inguinal, pelvic and para-aortic groups. Lymphography of the head and neck region has been done by Jackson et al[32] and Smith[21] despite obvious technical obstacles.

3. Lack of correlation between radiographic and pathological findings. Overlapping of lymph nodes, inflammation, fatty deposits, and fibrosis are a few of the factors that hinder an accurate radiographic interpretation. Incomplete or nonfilling of a metastatic node has hampered detection of early malignant spread. Kendall et al[33] have emphasized this point in a study of early lymph node metastases in breast cancer.

Comments

In our experience with 40 patients, we have not exceeded a total dosage of 20 ml. Ethiodol when two extremities are injected concomitantly. The only complications we have encountered were mild febrile reactions. These reactions tend to occur when the injection time is shortened. In only one case was a significant radiographic abnormality attributable to the injection detected in the lung fields.

Pulmonary disease was not considered a contraindication. Several patients had diffuse metastatic spread, and others had pulmonary emphysema. All tolerated the procedure well.

The mediastinal and mesenteric nodes were incidentally visualized in two patients. The former was noted in a young patient with Hodgkins' disease, and the latter, in a case of advanced carcinoma of the stomach. Obvious proximal lymphatic obstruction was present in both instances. These two cases indicate the possibility of mediastinal and mesenteric lymphography if proximal occlusion of the thoracic duct can be obtained.

Venolymphatic communications are not usually seen in "normal" lymphograms. The existence of these channels has been described in anatomical studies on animals by Yoffey and Courtice.[35] In advanced lymphatic obstruction, these communicating channels are often utilized.[36] We have observed venolymphatic communications on lymphography (Figure 6) in two patients, without evidence of lymphatic obstruction. Marrocu et al[34] have reported a similar phenomenon in a single case. The mechanisms by which these channels function certainly merit further investigation.

In another case, "collateral" lymphatic circulation was observed in the gluteal region in a postoperative lymphogram study on a case of carcinoma of the bladder in which radical pelvic node resection had been carried out. This phenomenon somewhat resembles arterial circulation where collaterals develop following arterial occlusion.

Among our studies, the examination has been found to be most helpful in lymphomas, as a guide to radiotherapy, and on postoperative follow-up investigations. In the identification of early metastases, correlation has not been too encouraging.

Conclusion

Lymphography is still in its infancy as compared to such established procedures as angiography and venography. Its diagnostic and therapeutic potentials have not been exhausted. At the moment, it is a valuable adjunct in clinical investigation, especially in the field of oncology.

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Ruptured Abdominal Aortic Aneurysm: Successful Excision in a Patient 89 Years of Age

HOWARD E. DORTON, M.D.*

Lexington, Ky.

This paper describes the salvage of an 89 year old patient with frank rupture of an abdominal aortic aneurysm. The advanced age of this patient, perhaps the oldest to recover following such a catastrophe, has prompted this report.

THE mortality following operation for correction of ruptured abdominal aortic aneurysm has been reported to be approximately 40% by Cooley and DeBakey,[1] and Shumaker and King.[2] This represents a salvage rate rather than a surgical mortality rate since the condition is usually 100% fatal. As one might expect, the mortality rates are increased among elderly patients. However, advanced age alone does not preclude a successful outcome providing other organ systems are reasonably normal. For example, Boyd[3] has reported the case of an 83 year old patient and Mahaffey[4] the case of an 85 year old patient, both of whom survived after prosthetic replacement of a ruptured abdominal aortic aneurysm and Knowles, Spencer and Steenburg[5] have reported the successful elective excision of a huge abdominal iliac aneurysm in an 89 year old patient.

This paper describes the salvage of an 89 year old white female patient with a ruptured abdominal aortic aneurysm. The advanced age of this patient, perhaps the oldest to recover following such a catastrophe, has prompted this report.

*Clinical associate professor of surgery, University of Kentucky Medical Center, Lexington, Ky.

Report of a Case

An 89 year old white female (born November 9, 1874) was admitted to Central Baptist Hospital at 1:00 p.m. on March 26, 1963, nine hours following the sudden onset of severe abdominal pain and vomiting. She was in a state of shock which had failed to respond to vigorous restorative measures, including two transfusions in an outlying hospital. It was thought that she had an intestinal obstruction.

Eight years previously she had had surgical correction of uterine procidentia at which time she was noted to have moderate cardiomegaly and a blood pressure of 190/100 mm. Hg. Otherwise, her health had been reasonably good and she had been quite active. Her physical appearance corresponded to her stated age. There was an ashen pallor to her skin which was sweaty and cold. The blood pressure was recorded at 60/0 mm. Hg. The pulse was 140 per minute, irregular, and barely perceptible. The abdomen was moderately distended, particularly on the left, and was tender. A diffuse pulsatile mass could be felt extending from the left costal margin to just below the umbilicus. Pulses could not be felt below the femoral regions. The hemoglobin was 9.5 Gm. with a hematocrit of 29. The urine had a specific gravity of 1.021 and was essentially normal chemically and microscopically.

After suitable preparations for blood replacement had been made and approximately ten hours following onset of symptoms a laparotomy was performed through a long midline incision. The aneurysm, which was about twelve centimeters in diameter, extended from two centimeters below the right renal artery to the bifurcation. It had ruptured anteriorly with massive retroperitoneal extravasation which displaced the right colon and cecum forward and spread behind the left colon and upward into the left renal area. After proximal and distal control the aneurysm was removed, sacrificing

the inferior mesenteric artery. Although there was moderate aneurysmal dilatation of both iliac vessels, it was elected to limit the excision at the bifurcation to reduce operating time. The proximal end of the transected aorta was of such poor quality that the proximal end of the prosthesis was cuffed and sutured to the end of the aorta with a runing 3-0 arterial silk suture. The cuffed portion was then turned upward to surround the friable aorta. The free proximal end of the graft was tacked to the aorta with several interrupted 3-0 silk sutures. This resulted in a telescoping of the proximal end of the aorta into the graft for a distance of two centimeters and substantially strengthened the proximal anastomosis. Distally a simple end-to-end continuous silk anastomosis was performed. Distal flow was re-established within thirty-five minutes following which good pulsations were noted in both iliac arteries.

After mass closure of the abdominal incision with buried figure-of-eight stainless steel wire sutures, it was noted that the right foot was quite waxy and white in color as compared with the left. Accordingly, under local anesthesia, the right popliteal area was exposed through an incision just below and medial to the knee as described by Morris, et al.[6] The artery was opened and a long clot extending proximally and distally was extracted. There was immediate excellent blood flow and after closure of the incision the popliteal artery pulsated satisfactorily. Following this, both lower extremities were noted to be of the same color although both were quite pale and cool. Pedal pulses could not be detected. Their status pre-operatively was not known.

The abdominal portion of the operation procedure required two hours and ten minutes and the entire procedure was completed in three hours. Seven pints of blood were employed, six during operation and one in the recovery unit. On the third post operative day the hemoglobin was 11.8 Gm. with a hematocrit of 39. Post operative recovery was relatively uneventful except that on the third post operative day she developed a continual diarrhea which was thought to be due to ischemia of the left colon. Endoscopic examination disclosed the colonic mucosa to be normal except for moderate edema. Although stool smears and cultures were negative for pathogens the patient was given staphcillin as a precautionary measure. The patient was ambulated on the seventh post operative day and dismissed from the hospital on the fifteenth post operative day.

Urinary output the first 24 hours post operative was 800 cc. This increased and remained adequate throughout. The blood urea nitrogen which was 30 mg. % on admission rose to 51 mg. % the day following surgery, then gradually fell to 22.5 mg. % at the time of discharge.

The patient remained quite active and ambulatory the next 17 months. Her only complaint was mild diarrhea which was kept under control by dietary restrictions and an occasional dose of Kaopectate. Unfortunately, on August 31, 1964, she fell and fractured the neck of her right femur. She was hospitalized for eleven days for a pinning procedure, following which she again became ambulatory. On January 15, 1965, she was readmitted to the hospital because of coronary thrombosis. She appeared to be convalescing satisfactorily from this but ten days after her last admission she expired quietly during sleep. She had survived the abdominal catastrophe for nearly two years. Throughout this period repeated abdominal examinations failed to reveal any vascular abnormalities.

Comment

The case here reported is of particular interest because of the advanced age of the patient. The relatively early operative intervention (10 hours) following rupture undoubtedly was of considerable importance in the successful outcome. In this regard it is interesting to note that the delay in Boyd's case was only two hours and in Mahaffey's case seven hours from the time of rupture. The immediate and late post operative diarrhea may have resulted from ischemia of the left colon although the bowel appeared normal at the termination of the operative procedure. Endoscopy on the third post operative day did show mucosal edema. Urinary output in this case was surprisingly good despite the fact that no osmotic diuretics were employed. The immediate removal of a clot from the right popliteal artery probably prevented loss of the involved extremity.

Summary

A case is reported of an 89 year old woman who survived for nearly two years following

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Intestinal Obstruction

M. Atik, M.D.* and John Hart, M.D**

INTESTINAL OBSTRUCTION, an old and common malady, presents numerous challenging problems to the physician and surgeon. The following case history is reported to illustrate some of these problems and to record a few recent advances in the successful management of this potentially dangerous disease.

Case History

M. J. (25820), a 49 year old white woman, underwent a vaginal hysterectomy and repair of cystocele and rectocele because of uterine prolapse and stress incontinence of urine on October 27, 1964, and was discharged from the hospital on November 2, 1964. She felt well until three days later, when she developed right flank and abdominal pain and vomited several times. She was re-admitted to the hospital on November 6, 1964.

Examination at the time of admission revealed a thin white woman who appeared to be experiencing severe abdominal pain. Her temperature was 99.6 degrees orally, blood pressure 90-60 mm. Hg and pulse 86 per minute and regular. Her head, neck, chest, heart and lungs were normal. The abdomen was slightly distended and diffusely tender with involuntary guarding and rebound tenderness. The right side was somewhat more tender than the left. Peristaltic sounds were not heard. No enlarged organs or masses could be palpated. There was a yellow-green vaginal discharge which grew *Proteus mirabilis* on culture. The rectocele repair was infected. Marked tenderness and guarding were present bilaterally on pelvic examination. The closed apex of the vaginal vault was tender and indurated. Both ovaries were tender. No unusual pelvic masses were palpated.

The patient's chest x-ray was normal; x-ray of her abdomen showed air in the small and large intestines. Urinalysis showed many bacteria, but was otherwise normal. The white blood cell count was 19,642 with 97 neutrophils, 2 lymphocytes and 1 monocyte, the hemoglobin was 11.6 gm. % and the hematocrit 37%. CO_2 content was 21 mM, Cl-101, Na+135 and K+4.0 mEq./L. The urine culture was negative.



FIGURE 1. Abdominal x-ray consistent with partial intestinal obstruction.

Hospital Course. The patient was thought to have pelvic cellulitis. She was treated with penicillin, streptomycin, and Chloromycetin® and I.V. fluids, but was not placed on nasogastric suction. During the next three days she remained afebrile. She stopped vomiting, and was thought to be better in general. Abdominal tenderness had decreased, and bowel sounds were heard. She passed a small amount of flatus, and on November 8, 1964, was given a liquid diet. The purulent discharge which was coming from the apex of the vagina persisted, however. A 6 cm. mass became palpable above and posterior to the vaginal cuff.

On November 9, 1964, she started vomiting again and became distended. Bowel sounds were not heard. An abdominal x-ray showed multiple air fluid levels in large and small bowels consistent with early partial intestinal obstruction (Fig. 1).

*Associate professor of surgery, University of Louisville School of Medicine.
**Senior resident, University of Louisville hospitals.

On November 10, 1964, the abdominal pain and distention were noted to be increased and hyperactive bowel sounds could be heard. There was diffuse abdominal tenderness and guarding. The patient was thought to have peritonitis and intestinal obstruction. A Miller-Abbott tube was passed into the stomach and surgical consultation was requested. At this time the patient appeared seriously ill. Her temperature was 100.3 degrees, her pulse weak and 92 per minute and her blood pressure 90/68 mm. Hg. She was in shock and oliguric (about 15 cc./hr.) despite the 3000 cc. of I.V fluids she had received over the preceding 24 hours. Her CO_2 content was 20.9 mM, Na+132, K+3.6, and Cl-78mEq./L. X-ray of the abdomen showed multiple distended loops of small bowel with little air in the colon (Fig 2). These findings were consistent with mechanical small bowel obstruction. The patient was therefore prepared for operation. She was rapidly given 3 liters of normal saline with sodium bicarbonate and KCl. Over a period of three hours, her blood pressure and urine output improved.

At operation, the entire peritoneal cavity was found filled with watery, purulent liquid which revealed no bacteria on smear and culture. As this liquid was aspirated and the loops of small bowel were carefully delivered from the abdominal cavity, many fresh adhesions were divided by sharp and blunt dissection and multiple intra-abdominal abscesses were encountered between the loops of bowel in the midabdomen, the right lower quadrant, and the pelvis. A complete mechanical obstruction of the small bowel caused by adhesions was present about 6 inches above the ileocecal valve. All abscesses were opened and drained. The abdominal cavity was repeatedly irrigated with 0.2% Kanamycin solution. Decompression of the bowel was achieved by a sterile Levine tube introduced via a gastrostomy through the pylorus and duodenum into the jejunum. The other end of this tube was brought out through a stab wound in the left upper quadrant. The vaginal cuff was necrotic and was opened by blunt dissection so that a sump drain could be placed in the pelvis and led to the outside via the vagina. Soft rubber drains were placed in the right lower quadrant through a stab wound. The abdominal incision was closed with steel wire and silk sutures in the skin.

During operation the patient received 3000 cc. of electrolytes and 1000 cc. of blood while her central venous pressure was repeatedly monitored. Antibiotics and I.V. fluid therapy were continued in the postoperative period and her G. I. tract was kept decompressed with suction on the tube in her jejunum. The sump tube in her pelvis was attached to suction and was irrigated several times daily with 1% Kanamycin solution. She was given 500 ml. of low molecular weight Dextran I. V. during operation and the day after surgery. Her recovery from anesthesia was prompt. Her vital signs remained stable, her blood pressure ranged between 114/70 and 140/70 mm. Hg, her hourly urine output was 30-60 cc./hr. and her serum electrolyte concentration was normal in the postoperative period. She became afebrile by the fourth day, and showed no



FIGURE 2. Abdominal x-ray showing progression of distention of the small bowel with little air in the colon and highly suggestive of complete mechanical small bowel obstruction.

evidence of wound infection or recurrence of intra-abdominal abscess. She took oral fluids six days after, a bland diet nine days after operation, and continued to recover rapidly. She was discharged from the hospital on the 14th postoperative day. During subsequent clinic visits she felt well, and had no complaints. The gastrostomy tube was removed on the 36th postoperative day.

Discussion

This patient presented three important problems—sepsis, intestinal obstruction and shock. The shock was primarily due to loss of blood volume. With established intestinal obstruction of over 24 hours' duration, a volume deficit of at least six liters could be expected. This loss is partly due to vomiting, partly due to translocation of fluid into obstructed gut and the peritoneal cavity and in the inflamed tissues. Prompt replacement of volume loss, which is perhaps the most common cause of shock in surgical practice, is desirable to prevent complications such as acute renal failure, and damage to the lungs and liver and other vital organs. It is also an essential part of preparation of the patient for the contemplated operative procedure. The amount, composition and speed of fluid therapy must be carefully considered. With the help of repeated venous pressure monitoring and hourly urine output recording, one can safely administer most of the estimated fluid requirement over a few hours. Proper interpretation of central venous pressure requires consideration of a patient's response to fluid therapy, the systemic arterial pressure and the urine output. In this regard the change in the venous pressure is

more important than the absolute value. Generally, when the venous pressure rises to 10-15 cm. of saline, additional fluid should be administered cautiously. This patient indeed received over seven liters of badly-needed fluid in eight hours during the preoperative and operative periods. The low molecular weight Dextran was infused to improve impaired microcirculation and tissue perfusions, the common sequelae to all forms of shock, and to prevent acute renal failure, especially in the presence of toxemia of sepsis.

The treatment of peritonitis and intra-abdominal abscess with systemic antibiotics alone, although given a fair trial early in the hospital course, could not be accomplished without adequate drainage. Local intraperitoneal irrigation with dilute Kanamycin solution is recommended to reduce the number of bacteria when and where sufficient antibiotic concentration cannot be reached promptly and effectively by the systemic route. This broad spectrum agent, in the concentration and manner used here, is a useful adjunct and free from serious toxicity.

During the early part of the patient's illness, her abdominal symptoms and signs were due to peritonitis and adynamic ileus, and the initial conservative management was justified. With progression of abdominal sepsis to frank abscess formation and failure of ileus to improve, and with x-ray evidence of mechanical small bowel obstruction, persistence of nonoperative management was considered dangerous. Perhaps one of the most important advances in the management of intestinal obstruction is an agressive attitude toward correction of obstruction before strangulation takes place. While the mortality from simple intestinal obstruction is 3-5%, with strangulation it is still reported to be 20-30%. A trial of tube decompression is justified only in the early adynamic postoperative period, in chronic repeated bowel obstruction, and as part of the preoperative management. If improvement is not achieved rapidly within a few hours, even in these circumstances, this mode of attack should be abandoned.

The operative decompression of the distended gut directly, or in some manner similar to this case, has several important advantages. It provides for early and effective decompression and removal of toxic products, improves microcirculation of the involved gut, and helps earlier return of effective peristalsis. It makes closure of the incision easy and contributes toward reduction of respiratory complications. The use of tube gastrostomy in the postoperative period has additional merits. It is safe, comfortable and may be left in place for weeks, can be opened or closed with a simple clamp and may be removed without difficulty. The tube in the small bowel thus left for several weeks may also provide for orderly formation of future adhesions between the loops of bowel, and hense may reduce the chance of recurrent intestinal obstruction.

Summary

Successful management of a patient with the triad of shock, sepsis and mechanical small bowel obstruction is described. Undue and protracted reliance on tube decompression and upon systemic antibiotics in the face of abscess formation is to be discouraged. Early operative intervention and rapid correction of fluid and electrolytes, guided by central venous pressure monitoring and by hourly urine output, operative decompression of the distended gut and the use of tube gastrostomy in the postoperative period, are recommended. Irrigation of the peritoneal cavity with dilute Kanamycin solution to combat local contamination and the use of low molecular weight dextran to improve microcirculation are suggested.

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Plan to take your family—

KMA Interim Meeting

DuPont Lodge, Cumberland Falls State Park, April 13-14

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could enjoy a family holiday in the mountains

SPECIAL ARTICLES

The Dilemma of Gradualism*

DELMAS M. CLARDY, M.D.

MR. CHAIRMAN, Senator Dominick, Senator Yarborough, Doctor Kernodle, distinguished guests and fellow physicians: I was asked a few days ago by Doctor Greathouse to make an address on this occasion, but I begged to make only a few introductory and welcoming remarks. Since that time I have changed my mind and have decided to say a few additional words because it would cost me several hundred dollars to go to Washington to talk to these senators, if I could get an audience. I have the audience, my ticket was gratis, this is a bargain, and I am not going to miss the opportunity.

For the information of those who do not know, the Kentucky Educational Medical Political Action Committee is a non-partisan, non-profit, political organization, supported by physicians and their wives, business people and well-wishers. It is disassociated from the Kentucky Medical Association for legal reasons. Its purpose is supposed to be to elect to Congress those people who are favorable to keeping American medicine the finest in the world. For the most part, our members and supporters are conservatives of both major political parties and our numbers were counted in the 27 million conservative votes last November. You may say we did not do so well. I say we did do well, but others did not do their parts; also, extreme methods were used against us both in the election and since.

For us to have a blind allegiance to a political party, just because our parents were Democrats or Republicans, has been and is a silly mistake. The party labels don't mean very much any more, because both parties are divided into conservative and liberal groups. It doesn't make much sense for Senator Harry Byrd to be in the Democratic party with Senator Paul Douglas, or Senator John Tower to be in the Republican party with Senator Jacob Javits, or even our own Senator Cooper. I must give credit to my relative, Senator Strom Thurmond, who had the backbone to remove his party affiliation to the side where he casts his vote. So far as I know, this was done only one other time in recent history, and that was by Senator Wayne Morse.

The only thing I am going to say about socialized medicine is that it is only a part of the plan in the creation of the "Great Society" and this parallels what Lenin had in mind when he said, "Socialized medicine is the keystone to the arch of the Socialist State". What I have to say covers more than our own private and selfish interests. I want you to hear it; I want the senators to hear it, think about it, go back to Washington and discuss it with their colleagues. More is at stake than the destruction of the world's finest medical care and the enslavement of the American physician.

We, as a nation, have arrived at a frightful dilemma through the process of gradualism. Each president and each congress have added a few more socialistic laws to our books until we find ourselves in a sorry entangled mess without knowing just how we got there. Sidney Webb, who was one of the founders of George Bernard Shaw's socialist Fabian Society, spoke of the Communist conspiracy as "The doctrine of inevitability of gradualism." Patient gradualism is slow, piece-meal changes in laws, government, morality, economics and education. The changes are so gradual that there is little opposition. The liberals who like to call themselves moderates, promote it as "inevitable change" and "progress".

Nearly 200 years ago, a British historian by

*This article was presented as a speech by Doctor Clardy, immediate past president of KMA, at the annual KEMPAC dinner, September 20, 1965.

the name of Alexander Fraser Tyler wrote this historical truth: "A Democracy cannot exist as a permanent form of government. It can exist until the voters discover that they can vote themselves largess out of the public treasury. From that moment on, the majority always votes for the candidate promising the most benefits from the public treasury with the result that Democracy always collapses over a loose fiscal policy, always followed by a dictatorship." It appears we are well on the way.

Another line we are following almost to the letter is that original personal doctrine of Karl Marx: "From each according to his ability, to each according to his need." This statement was taken from an address of January 15, 1964, by a high official in Government: "We are going to try to take all of the money that we think is unnecessarily being spent, and take it from the 'haves' and give it to the 'have nots' that need it so much." This parallel of philosophy should frighten every red-blooded American into a determined effort to do something to save his country.

What can we do? There is a lot we can do and a lot we must do at the grass roots level, if we are to keep alive the flame of freedom. We must work and fight for the principles which made our country great. Thomas Paine once said, "Those who expect to reap the blessings of freedom must, like men, undergo the fatigue of supporting it." We must adopt the firm attitude of the great Winston Churchill when he spoke to the British people in their darkest hour: "We shall fight on the beaches, we shall fight on the landing grounds, we shall fight in the fields and in the streets, we shall fight in the hills, we shall never surrender." To quote another present-day patriot, "When freedom is at stake, our silence is not golden. It is yellow."

It is my belief that every physician's first duty is to his God, and then to his country, and he accepts it as such. This has been demonstrated many times throughout the history of this country. Six of the signers of the Declaration of Independence were physicians. A physician completed the ride for which Paul Revere was given the credit. There are other instances too numerous to mention where unsurpassed physician-gentlemen have valued their sacred honor above their lives and fortunes.

There are those who say physicians should not engage in politics or take part in controversial affairs, but I believe they should. Every physician should use every means at his disposal to mold public opinion when he is honest and knows he is right. He should write to the newspapers, senators and congressmen, express himself fearlessly in public and let the chips fall where they may. No doubt he would lose some patients if they do not like the views of their outspoken doctor, but the physician who fails in this duty is as culpable as the politician who will do anything to get a vote.

We must keep the faith and fight the good fight. We must never surrender. The following was written by a Canadian physician, Doctor John McCrae, shortly before he died of wounds he received in Flander's Field in World War I:

"Take up our quarrel with the foe!
To you from failing hands we throw
The torch; be yours to hold it high.
If ye break faith with us who die
We shall not sleep, tho poppies grow
In Flander's Field."

Like you, your County Society Secretary is a busy man.

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EDITORIALS

This Is The Year

THIS is the year to which we as physicians have looked with apprehension and dread for a generation. Medical care legislation covering Americans over age 65 was enacted into law in July of 1965 and will become effective July 1st, 1966. It becomes a part of the social security program which was first enacted and became effective just 30 years ago. That it is a part of and the result of political expedience more than a concern for the health of older Americans few of us question. It cannot, however, be charged to the political "mechanations" of the Democratic party or of the Republican party, nor can it be blamed on the lethargy and indifference of physicians. Rather, we think, it came as the result of a demand for security and protection at government cost and management, prompted by social planners. This ever-increasing trend toward socialistic government is world wide. The overwhelming majority by which the law was passed in both Houses of Congress tends to remove it from the responsibility of any group or political party.

Recently a young and very gifted physician addressed members of the Jefferson County Medical Society and in his remarks stated that had the medical profession been alert and united in an energetic effort during the past generation this legislation would not now be in effect. He was undoubtedly not here or not interested in medical statesmanship 30 years ago when complete socialization of medicine was a serious threat. He could not have had a very fresh memory of the leadership and organized opposition of the medical profession to the socialization of medicine before World War II and immediately after. We were successful then in preventing complete socialization of medicine which would have been effective under the Murray-Wagner-Dingle or Forand proposals; we lost our effort to prevent the present limited change.

The present legislation is proposed to cover approximately 19 million people over 65 years of age who are beneficiaries of Social Security or the Railroad Retirement Act and about 3½ million people not included in these categories who are regarded as eligible for the benefits of its provisions. With this 23 million added to those citizens who are covered by other forms of medical care, such as federal employees and veterans, the total number of Americans under federally administrated medical care does not exceed 50 million — more than three-fourths of the population of the United States is, therefore, still under free medical care as we believe it and cherish it. This is a condition not enjoyed by any other major government in the world and a far less serious threat to our American way of life and medical practice than we would have had under the previously proposed types of legislation.

It is true that the medical profession with the strong support of private insurance industries, Farm Bureau, Chamber of Commerce, and numerous other effective allies, failed miserably in our opposition to the passage of public law 89-97, but we have not failed in a substantial preservation of our freedom of practice and individual initiative. As we prepare for this change let us not forget that there are many favorable circumstances for which we should be grateful.

A free choice of physicians will be affected only in part. In those circumstances where the patient is obliged to obtain his medical care from recognized and accredited hospitals and facilities which are not available in his own home locality, it will often be necessary for him to forego the services of the physician of his choice in order to avail himself of institutional

and specialist care as provided in the new program. It remains yet to be seen how great a difference this will make in our physician-patient relationship, but it is still an undesirable element.

The program promises not to be administered ruthlessly by federal officials without the consultation, advice and guidance of physicians. On November 11th the President announced the names of 16 members of the Health Insurance Benefits Advisory Council to assist in setting up standards, policies and procedures for implementing the hospital and physicians' participation in this program. Nine of these council members are physicians. It is true that most of them are physicians connected with institutions or foundations and that private practicing physicians have small representation. However, theoretically we will have an opportunity to express through this committee our preferences and advice in the administration of the plan.

It is proposed that private insurance companies and Blue Cross and Blue Shield Organizations, having had wide experience in the administration of health care, share the responsibility in the administration of this new program. Physicians generally have come to rely upon and feel some confidence and protection in their dealings with these carriers.

One of the great sources of apprehension is the very probable over-crowding of hospitals and nursing homes and increased demand upon physicians for medical service. How great will be this element no one can even approximately estimate. There is a requirement for hospital review committees which may somewhat effectively control the over-crowding of our institutions, and there is the awareness that the rest of the population must continue to have adequate health facilities as well. The AMA through its House of Delegates has insisted that such hospital review committees be composed only of physicians.

Whether due to the proposed new manner of practice or coincidental there has come during the past year the determination among hospital-based physicians (roentgenologists, pathologists, and anesthesiologists) to separate their financial operations from the hospital and to perform as individual physicians. They thereby return to the main body of medicine and regain their identity. This we regard as a healthy and helpful development. They become more specifically identified with the medical team rather than the hospital organization. This difference will undoubtedly stimulate greater unity in the medical profession at large.

Mr. Robert M. Ball, Commissioner of Social Security, in an address at Harrisburg, Pennsylvania on November 30th, 1965, stated, in discussing the expanded requirement in the Health Program, "It is not so much new buildings and facilities that we need as it is more doctors, more nurses, and more health technicians of all kinds." The need for more hospital beds will certainly be urgent far beyond our present expansion and new building program. Fourteen new medical schools are expected to be in operation in the United States by 1970, increasing our present number from 88 to 102, and should increase our annual output of physicians by more than a thousand. We are already short of physicians, nurses, and medical personnel and with the impending health programs it will be a long time before we can provide an adequate number. In the meantime we will just have to do the best that we can.

The question in the mind of every practicing physician is what will be his attitude toward cooperation in our new and expanded health program. Trustees and delegates of the American Medical Association have given a great deal of time and intelligent thought to this problem and their guide lines as proposed to the profession at large seem to us reasonable and fair. Of course, we will continue to practice the best medicine we know in each individual case. We will cooperate whenever possible and at all feasible with the new program. The health care of the people is our first concern and responsibility, whether it be helped or encumbered by federal intervention. As an organized body we will strive in every way possible to make the program more effective and less objectionable.

SAM A. OVERSTREET, M.D.

ORGANIZATION SECTION

Variety of Topics to be Covered At Interim Meeting Apr. 13-14

The eight speakers for the 1966 KMA Interim Meeting, to be held at DuPont Lodge, Cumberland Falls, April 13 and 14, have been committed, according to program chairman Everett H. Baker, M.D., Louisville.



Doctor Lee

"We feel that we will be able to present a truly outstanding program", Doctor Baker said. "Some of our people are recognized authorities in their fields and all are nationally known."

The meeting will open Wednesday evening, April 13, with a dinner. The program for the evening will be a condensed and hard-hitting panel discussion on utilization and review committees. This panel will express the views of the Social Security Administration, hospitals, Blue Cross-Blue Shield, and the American Medical Association, Doctor Baker reported.

The next morning the general session will feature a talk by one of the top health insurance consultants in labor, a general discussion on the implementation of PL 89-97, and a discussion on the Appalachian Regional Commission's work with special emphasis on health programs.

The meeting will close with a luncheon, at which the featured speaker will be James Z. Appel, M.D., president of the American Medical Association. Doctor Appel's topic will be announced later.

Also taking part in the program will be Philip R. Lee, M.D., assistant secretary for Health and Scientific Affairs in the U.S. Department of Health, Education and Welfare. Doctor Lee formerly served as director of Health Services for the Agency for International Development (AID) in the Office of Technical Cooperation and Research.

He is a graduate of the Stanford University School of Medicine and a member of the AMA, the American Public Health Association, the American College of Physicians, and the American Federation for Clinical Research.

Birth Defects Center Treats 120

The Birth Defects Center at Louisville General Hospital treated 120 patients during its first year of operation, according to JoAnne Sexton, M.D., Center director. The Center is principally concerned with the diagnosis and treatment of children born with nervous-system defects.

KMA Board Chooses Dr. Seeley Fifteenth District Trustee

E. C. Seeley, M.D., London, was elected December 8 by the KMA Board of Trustees to serve as Fifteenth District trustee, filling the unexpired term of Robert E. Pennington, M.D., London, who was chosen president-elect of the Association in September.



Doctor Seeley

Doctor Seeley was elected by the Board from a list of nominees submitted by the delegates of record from the counties making up the Fifteenth District, as stipulated in the KMA By-laws, Chapter VI, Section 7.

The new trustee is immediate past president of the Kentucky Academy of General Practice and a former member of its Board of Directors. He has served as chairman of the KMA Committee on General Practice and as a member of its Council on Medical Education and Hospitals and the Committee on Federal Medical Services.

Doctor Seeley is a former secretary and president of the Laurel County Medical Society and a member of the County Board of Health. He was graduated from the University of Louisville School of Medicine in 1947 and has been in practice at London since 1951.

KMA Trustee District Meetings Outlined for Jan. and Feb.

Everett H. Baker, M.D., Louisville, KMA president, was the featured speaker at the Second Trustee District meeting held at Owensboro on January 11, according to W. Gerald Edds, M.D., Calhoun, trustee for that district.

"The Responsibilities of Physicians on the Local Scene", was the subject of Doctor Baker's talk. The scientific portion of the program was presented by Lloyd G. Yopp, M.D., Louisville, who discussed "Diabetes and Its New Developments".

Doctor Baker will also appear on the program of the First Trustee District Meeting at Paducah January 27, Joseph R. Miller, M.D., Benton, First District trustee, has announced. His subject will be the same.

Physicians planning to attend the First District meeting are asked to note that the date of the meeting will be January 27, rather than the 26th, as was previously announced in *The Journal.*

(Continued on next page)

The Tenth Trustee District is making plans for a program to be presented by the Kentucky Educational Medical Political Action Committee (KEMPAC) at its February 8 meeting in Lexington, according to the trustee for the Tenth District, Douglas E. Scott, M.D., Lexington.

Doctor Scott has announced that the meeting will be held in conjunction with the regular monthly meeting of the Fayette County Medical Society. Plans for the program include the presentation of tape-recorded speeches made in Sepetmber at the annual KEMPAC dinner by Senators John Dominick of Colorado and Ralph Yarborough of Texas.

Dr. Willard Resigns as Dean; Will Keep Vice-Presidency

William R. Willard, M.D., Lexington, who served as first Dean of the College of Medicine at the University of Kentucky and later became vice-president for the medical center, resigned late in November as dean.



Doctor Willard

According to published reports, the work load had expanded in each position to such a degree that Doctor Willard felt it necessary to surrender his deanship.

It is expected that a new dean will be selected by the University at an early date. There has been no announcement as to who is being considered or when the new dean will take office.

Fifth and Eighth KMA Districts Schedule Meetings in Apr.

Two KMA trustee districts have scheduled meetings for the month of April, according to announcements at press time. Invitations will be mailed from the trustee of each district to physicians in that district several weeks before the meeting, giving full details of the program. You are urged to watch for your invitation and to make plans to attend.

W. Donald Janney, M.D,. Covington, trustee for the for Thursday, April 7, to be held in Covington. Eighth District, has called a meeting of his members

Alfred O. Miller, M.D., Louisville, Fifth District trustee, has scheduled the meeting of that district for Monday, April 18 at the Medical Arts Building in Louisville.

Additional information on these and other meetings will be printed in *The Journal* as soon as it is available.

The new expanded 1966 KMA Legislative Key Man booklet has been put together at considerable time and effort and will be distributed at the January 12 meeting of the KMA Legislative Key Men.



Owen B. Murphy, M.D., Lexington, center, chairman of the American Medical Association's Committee on the Medical Aspects of Sports, is shown above with two other members of the original committee, Allan J. Ryan, M D., left, of Madison, Wis., and Thomas B. Quigley, M.D., Boston, during the recent AMA meeting in Philadelphia. All three concluded their terms of service on the committee. Doctor Murphy is chairman of the KMA Committee on School Health.

Dr. Long at White House Meeting

Robert C. Long, M.D., Louisville, attended a White House conference on international cooperation November 28-December 1 as a representative of the American Medical Association.

Doctor Long is a member of the AMA Board of Trustees and a former delegate from the Kentucky Medical Association to the AMA. The conference was called in response to the United Nations' resolution asking member nations to observe the organization's 20th anniversary.

Dr. Quertermous in AMA Post

Despite an acute case of laryngitis which he suffered just prior to the AMA meeting, John C. Quertermous, M.D., KMA delegate to the AMA, was able to chair the important reference committee on legislation and public relations at the winter meeting of the American Medical Association in Philadelphia November 28-December 1.

In addition to a number of reports from officers, councils, and others, ten resolutions were referred to Doctor Quertermous' committee.

Dr. Brockman Returns from VN

George F. Brockman, M.D., Greenville, speaker of the KMA House of Delegates, returned early in December from a two-month tour of duty as a volunteer physician in Vietnam, providing medical care for civilians.

Doctor Brockman was a member of a medical team serving in that country under the auspices of *Project Vietnam* sponsored by the American Medical Association. *The Journal* will carry a special article in February by the Greenville physician describing his experiences during a day in Vietnam.

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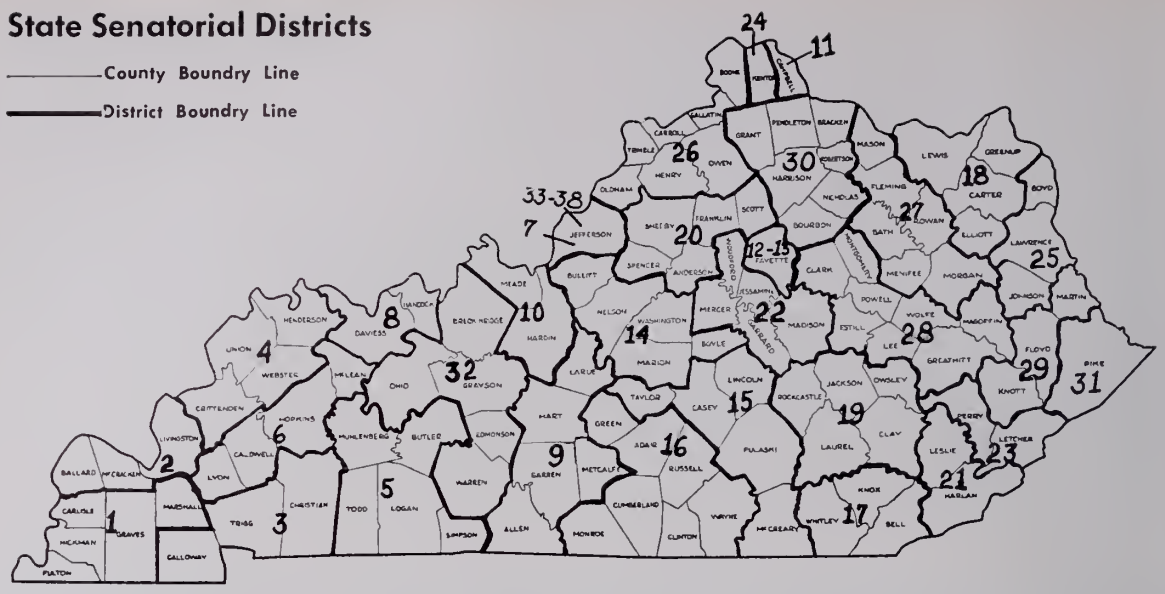
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Senators and Representatives Listed for 1966 Session

Democrats will continue to hold the edge in the 1966 Kentucky General Assembly, both in the House and Senate. In the House, 64 of its 100 members will be Democrats and 36 Republicans. There will be 37 new members. Of the 38 Senate seats, there will be 26 Democrats and 12 Republicans. Of the total members, 13 will be new.

In order to provide you with information concerning your 1966 legislators, The Journal is again printing a list of their names, addresses, and districts, together with maps showing the counties they serve.

Kentucky General Assembly 1965 Members of Senate

District	Home County	Senators
1	Graves	George G. Brand (D), Mayfield
2	McCracken	Tom Garrett (D), Paducah
3	Calloway	Owen Billington (D), Murray
4	Henderson	William L. Sullivan (D), Henderson
5	Simpson	Thomas M. Brizendine (D), Franklin
6	Hopkins	Richard L. Frymire (D), Madisonville
7	Jefferson	Richard Chin (R), Valley Station
8	Daviess	Wendell H. Ford (D), Owensboro
9	Barren	James H. Newberry (D), Hiseville
10	Hardin	Walter (Dee) Huddleston (D), Elizabethtown
11	Campbell	Donald L. Johnson (R), Alexandria
12	Fayette	C. Gibson Downing (D), Lexington
13	Fayette	Shelby C. Kinkead (D), Lexington
14	Bullitt	J. D. (Jiggs) Buckman (D), Shepherdsville
15	McCreary	O. O. Duncan (R), Whitley City
16	Cumberland	William C. Mann (R), Burkesville
17	Bell	Durham W. Howard (R), Pineville
18	Elliott	James E. Lewis (D), Sandy Hook
19	Clay	Pleaz William Mobley (R), Manchester
20	Franklin	Lawrence W. Wetherby (D), Frankfort
21	Leslie	Clay Gay (R), Hyden
22	Madison	Edward A. Murphy (D), Richmond
23	Perry	William Engle (D), Hazard
24	Kenton	John J. Maloney (D), Covington
25	Johnson	Wendell Van Hoose, (R), Tutor Key
26	Carroll	Tom Harris (D), Worthville
27	Fleming	Ed J. Kelly (D), Flemingsburg
28	Breathitt	John Raymond Turner (D), Jackson
29	Floyd	Fairis Johnson (D), Martin
30	Harrison	Wilson Palmer (D), Cynthiana
31	Pike	Foster Spence (R), Pikeville
32	Warren	Floyd Hayes Ellis (D), Rockfield
33	Jefferson	Bernard J. Bonn (D), Louisville
34	Jefferson	Walter S. Reichert (R), Louisville
35	Jefferson	Martin J. Duffy (D), Louisville
36	Jefferson	Scott Miller, Jr., (R), Louisville
37	Jefferson	C. W. A. McCann (D), Louisville
38	Jefferson	Vernon C. McGinty (R), Louisville

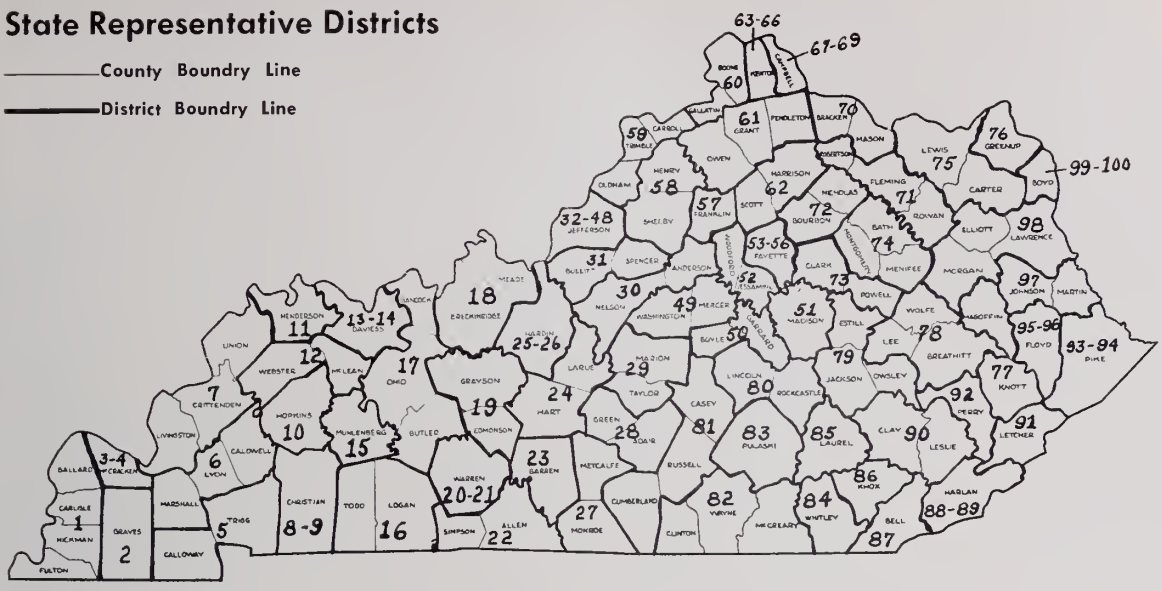
Kentucky General Assembly 1965 Representatives

District	Home County	Representative
1	Fulton	Henry Maddox (D), Hickman
2	Graves	Lloyd Clapp (D), Wingo
3	McCracken	Julian M. Carroll (D), West Paducah
4	McCracken	Fred Morgan (D), Paducah
5	Calloway	Charlie Lassiter (D), Murray

State Representative Districts

———— County Boundry Line

———— District Boundry Line



6	Marshall	Shelby McCallum (D), Benton
7	Livingston	George F. Harris (D), Salem
8	Christian	John O. Hardin, III (D), Hopkinsville
9	Christian	James E. Bruce (D), Hopkinsville
10	Hopkins	John Henry Cox (D), Madisonville
11	Henderson	John Stanley Hoffman (D), Henderson
12	McLean	Richard Hopkins (D), Calhoun
13	Daviess	John D. Miller (D), Owensboro
14	Daviess	R. E. Hale (D), Owensboro
15	Muhlenburg	Fred Wallace, Jr. (R), Central City
16	Todd	Paul E. Young (D), Allensville
17	Ohio	Theron Kessinger (R), Beaver Dam
18	Meade	C. H. Pile (D), Guston
19	Edmonson	Damon Majors (D), Caneyville
20	Warren	A. E. Tucker (D), Bowling Green
21	Warren	Edward G. Brown (D), Bowling Green
22	Allen	Raymond H. Barber (D), Scottsville
23	Barren	Paul Allen (D), Glasgow
24	Larue	James E. Bondurant (D), Hodgenville
25	Hardin	Sam H. Watkins (D), Elizabethtown
26	Hardin	Martin Louis Straney (D), Radcliff
27	Metcalfe	Wallace Bartley (R), Summer Shade
28	Green	Frank Sartin (R), Greensburg
29	Marion	James E. Whitlock (D), Lebanon
30	Nelson	Joseph Bernard Keene (D), Bardstown
31	Spencer	Stuart S. Kelly (D), Taylorsville
32	Jefferson	E. Bruce Blythe, Jr., (R), Louisville
33	Jefferson	Allen E. Russell (R), Louisville
34	Jefferson	Louis E. Ballenger (R), Louisville
35	Jefferson	Charles W. Vanover (R), Louisville
36	Jefferson	Clarence R. Miller (D), Louisville
37	Jefferson	Fallis Vernon Buky (R), Louisville
38	Jefferson	Dexter S. Wright (R), Louisville
39	Jefferson	Bob Henry Eicher (R), Louisville
40	Jefferson	George R. Siemens (D), Louisville
41	Jefferson	Jesse P. Warders (R), Louisville
42	Jefferson	Charles A. Brady (R), Louisville
43	Jefferson	Norbert Blume (D), Louisville
44	Jefferson	Charles J. Jones (R), Louisville
45	Jefferson	Jesse O. Johnson (R), Louisville
46	Jefferson	Melvin Thomas Riddle (R), Louisville
47	Jefferson	James M. Caldwell (R), Lousiville
48	Jefferson	Eugene P. Stuart (R), Louisville
49	Washington	John M. Smothers (D), Springfield
50	Boyle	Howard P. Hunt, Jr., (D), Danville
51	Madison	Robert L. Leeds (D), Richmond
52	Jessamine	John C. Bourne (D), Nicholasville
53	Fayette	Foster Pettit (D), Lexington
54	Fayette	Ted R. Osborn (D), Lexington
55	Fayette	Don Ball (R), Lexington
56	Fayette	John Y. Brown, (D), Lexington
57	Franklin	Ralph Bates (D), Frankfort
58	Henry	Louis T. Peniston (D), New Castle
59	Oldham	Otis R. Chaudoin (D), Pewee Valley
60	Boone	Dan J. Roberts (D), Walton
61	Grant	Franklin Webster (D), Williamstown
62	Scott	W. K. Henry (D), Georgetown
63	Kenton	Kenneth F. Harper (R), S. Ft. Mitchell
64	Kenton	Philip E. King (D), Covington
65	Kenton	John J. Isler (D), Covington
66	Kenton	Gus Sheehan, Jr., (D), Covington

(Continued on next page)

67	Campbell	James E. Murphy (D), Newport
68	Campbell	Eugene Ostertag (D), Ft. Thomas
69	Campbell	Henry Overman (D), Ft. Thomas
70	Mason	Mitchel B. Denham M.D. (D), Maysville
71	Rowan	Sherman R. Arnett (D), Clearfield
72	Bourbon	Brooks Hinkle (D), Paris
73	Powell	B. E. Billings (D), Stanton
74	Montgomery	Mrs. Nell Guy McNamara (D), Mt. Sterling
75	Lewis	Wayne Secrest (R), Vanceburg
76	Greenup	W. Terry McBrayer (D), Greenup
77	Knott	W. R. Smith (D), Hindman
78	Breathitt	Russell Reynolds (D), Jackson
79	Estill	C. H. Bicknell (R), Irvine
80	Lincoln	William H. De Marcus (R), Stanford
81	Casey	Siler Floyd (R), Yosemite
82	McCreary	Archie Brown (R), Stearns
83	Pulaski	Leonard R. Hislope (R), Somerset
84	Whitley	Will K. Peace (R), Williamsburg
85	Laurel	Dexter McCowan, (R), Mershons
86	Knox	Buford Clark (R), Barbourville
87	Bell	Harry M. Hoe (R), Middlesboro
88	Harlan	Paul Short (R), Harlan
89	Harlan	Bill Criscillis (D), Loyall
90	Clay	John E. White (R), Manchester
91	Letcher	William R. Jordon (D), Jenkins
92	Perry	Alex McIntyre, Jr., (R), Hazard
93	Pike	James E. Hunt (R), Fedscreek
94	Pike	Gether Irick (D), Stone
95	Floyd	W. J. Reynolds (D), Allen
96	Floyd	Ben Martin (D), Drift
97	Martin	Albert Dempsey (R), Inez
98	Elliott	Lynn B. Wells (D), Sandy Hook
99	Boyd	Thomas E. Chapman (D), Rush
100	Boyd	Charles D. Wheeler (R), Ashland

Health Sciences Symposium Set

The University of Kentucky Medical Center will hold a Symposium on Health Sciences Communications on February 16 and 17. Ellis A. Johnson, M.D., coordinator of scientific communications activities in the Department of Health Education and Welfare, will be a featured speaker. Other papers will be presented by a guest faculty of outstanding medical educators and representatives of communications facilities.

ARHI Plans Fund-Raising Drive

A National campaign to raise $3,565,000 for operating capital for the ten Appalachian Regional Hospitals in Kentucky and West Virginia will be headed by Donald C. Cook of New York, president of the American Electric Power Company.

Stating that "What happens in Appalachia concerns every American", Mr. Cook added, "Our goal is to provide these hospitals with enough operating capital to enable them to continue their flow of life-sustaining services to the people of Appalachia who depend on them". The drive will get under way immediately.

DEPROL®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

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normal sleep quickly
by helping
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calm associated anxiety,
tension, and rumination

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Ky. Physicians Represented At AMA Clinical Meeting

J. Thomas Giannini, M.D., Louisville, KMA's senior delegate to the American Medical Association, led the Kentucky delegation, including delegates John C. Quertermous, M.D., Murray, and Charles C. Rutledge, M.D., Hazard, at the AMA Clinical Convention in Philadelphia November 28-December 1.

It was Doctor Rutledge's first regular meeting of the AMA House of Delegates as a delegate, as well as the first for his alternate, David B. Stevens, M.D., Lexington. Other alternates attending were Charles G. Bryant, M.D., Louisville, and William W. Hall, M.D., Owensboro.

Also attending the sessions were Robert E. Pennington, M.D., London, KMA president; and Henry B. Asman, M.D., Louisville, secretary.

The Kentucky delegation held three caucuses, which were well attended by delegates, officers, members, and the deans of Kentucky's two medical schools, during the sessions of the House.

AMA Lists Ky. M.D.s Registered At Philadelphia Sessions

Kentucky physician-registration totaled 35 at the American Medical Association's annual Winter Clinical Convention in Philadelphia November 28-December 1, according to registration figures released by Lloyd W. Prang, manager of the AMA Physicians' Records Section.

Registration figures for the Convention totaled 9,423, including 4,619 physicians, according to the last available report. Kentucky physicians registered at the meeting are listed below.

George P. Archer, M.D., Prestonsburg
Henry B. Asman, M.D., Louisville
Charles G. Bryant, M.D., Louisville
M. R. Cronen, M.D., Louisville
I. K. Edwards, M.D., Madisonville
Louis M. Foltz, M.D., Louisville
Hoyt D. Gardner, M.D., Louisville
Brian P. Geoghegan, M.D., Lexington
J. Thomas Giannini, M.D., Louisville
R. F. Greathouse, M.D., Louisville
John W. Greene, Jr., M.D., Lexington
W. M. Hall, M.D., Elizabethtown
William W. Hall, M.D., Owensboro
Daryl P. Harvey, M.D., Glasgow
L. C. Hess, M.D., Florence
Paul A. Keeney, M.D., Louisville
Robert C. Long, M.D., Louisville
Lewis Martin, M.D., Adairville
Terrell D. Mays, M.D., Earlington
Owen B. Murphy, M.D., Lexington
John A. Naber, M.D., Southgate
Edmund D. Pellegrino, M.D., Lexington
Robert E. Pennington, M.D., London
Nicholas J. Pisacano, M.D., Lexington
John C. Quertermous, M.D., Murray
Charles C. Rutledge, M.D., Hazard
L. J. Singerman, M.D., Pleasure Ridge Park
Donn L. Smith, M.D., Louisville
Richard C. Spear, M.D., Louisville
David B. Stevens, M.D., Lexington
Borys Surawicz, M.D., Lexington
John H. Willard, M.D., Harlan
William R. Willard, M.D., Lexington
John D. Winebrenner, M.D., Louisville
Carroll L. Witten, M.D., Louisville

KMA and School Representatives To Meet at Park Mammoth

Representatives of the University of Louisville and the University of Kentucky schools of medicine will meet with a similar group from KMA at Park Mammoth Resort on January 21-23 to discuss medical education in the state, Henry B. Asman, M.D., Louisville, conference chairman, announced recently.

The stated purpose of the program is to discuss matters of mutual interest in furthering understanding and facilitate the programs of the schools and KMA. Thirty KMA representatives and 15 faculty members from each school will attend, Doctor Asman said.

At an agenda committee meeting held December 8, plans were laid for a program which will be interesting and beneficial to all the conferees, the chairman reported.

Walter Wiggins, M.D., secretary of the AMA Council on Medical Education, will be the featured speaker at the dinner to be held Saturday evening.

Formal presentations at the day sessions will include such topics as "What the Medical Profession Expects from the Medical Schools", "The Role of the Medical School and its Relationships with the Practice of Medicine", "Changes and Trends in Medical Education", and "The Future of General Practice". Each will be followed by a discussion period. The Conference will close at noon Sunday, January 23.

Blue Shield Reports Gains

The National Association of Blue Shield Plans recently reported a third-quarter enrollment record for 1965. Gains for the first nine months of the year brought enrollment to 57,286,041.

Third-quarter gains of 438,856 were posted by 56 Plans, with 26 showing losses of 129,412. Three showed no change.

Lymphography

(Continued from page 49)

34. Marrocu, F., Cossu, F.: *Venolymphatic communication observed during lymphography with an oily contrast medium.* A case report. Acta Radiol. (Diagn.) (Stockholm) *2:* 205-208, 1964.
35. Yoffey, J. M., and Courtice, F. C.: *Lymphatics, lymph and lymphoid tissue.* Harvard University Press, Cambridge, Massachusetts. 1956.
36. Perez-Tamayo, R., Thornbury, J. R., and Atkinson, R. J.: *"Second-look" lymphography.* Amer. J. Roentgen. *90:* 1078-1086, 1963.

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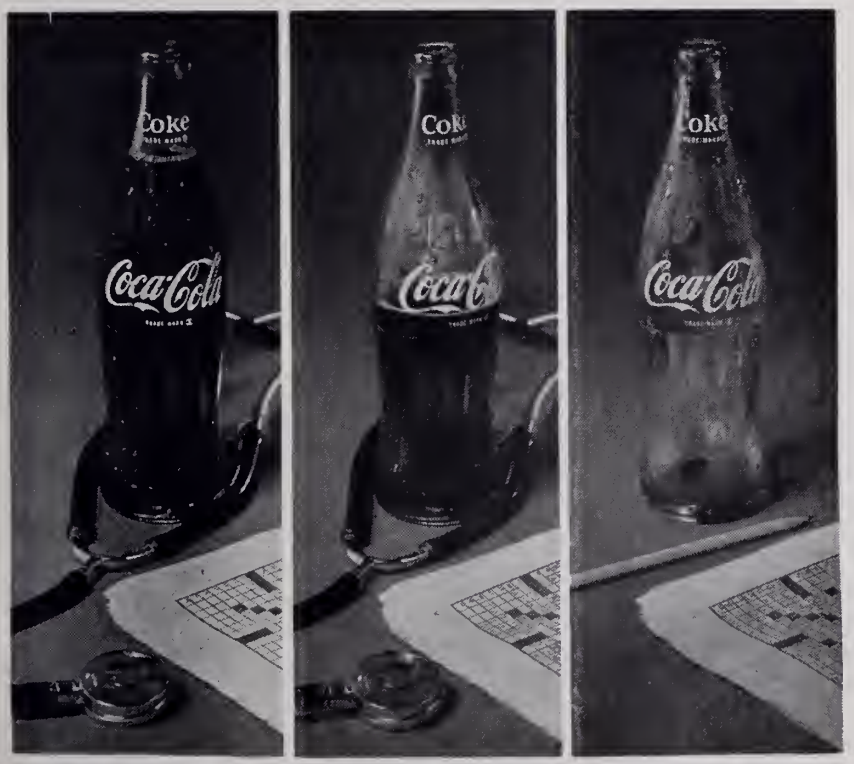
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Principles of Medical Ethics*

Preamble

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

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* *On the recommendation of the KMA Council on Legislative Activities, the Board of Trustees voted to request the Editor to publish these Principles in this issue.*

to help relieve pain
in common
anorectal disorders

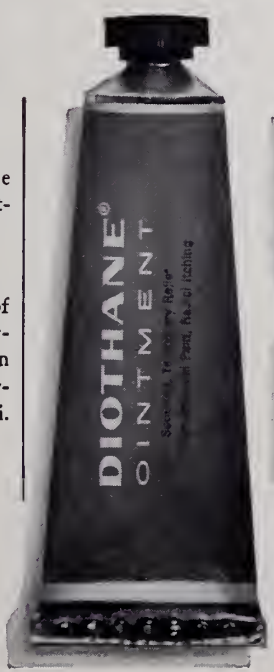
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INDICATIONS:
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COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
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AMA House of Delegates Considers Federal Health Care Laws, Dues, Abortion and Sterilization in Busy Sessions

Because of the unusual significance to the individual physician in the practice of medicine today, the editors are printing below a detailed summary of the actions of the American Medical Association's House of Delegates during the AMA Clinical Convention November 28-December 1 in Philadelphia. You are urged to read this report.

"Usual and customary" fees and prevailing fees, abortion and sterilization, billing and payment for medical services, membership dues, organization of the House of Delegates, and federal health care laws were among the major subjects acted upon by the House of Delegates at the American Medical Association's 19th Clinical Convention held Nov. 28-Dec. 1 in Philalelphia.

President James Z. Appel in his address to the House on Sunday described medicine's efforts "to guide in the best possible direction the actions that government agencies are now taking to activate existing law (PL. 89-97)." He then reviewed the activities and responsibilities of the six technical advisory committees under the Medicare law.

"Their suggestions have been received favorably in most instances," he said. "And we are hopeful that they will be translated into the final published regulations . . . (but) we know that in certain significant instances this will not be true".

Final registration reached a total of 9,423, including 4,619 physicians.

"Usual and Customary" and Prevailing Fees

One of the most controversial issues before the House and the Reference Committee on Insurance and Medical Service was the "usual and customary" fee concept and the prevailing fees program of the National Association of Blue Shield Plans.

The House reaffirmed its support of the "usual and customary" fee concept as the basis for reimbursing physician participants in government programs at all levels of government. It also urged "the individual physician's usual and customary fee concept to all third parties".

It took this action after modifying a Board of Trustees' report on the new "prevailing fees" program of NABSP. The modified report recommended:

"That the concept of the prevailing fees program of the NABSP be noted as one of the methods of compensation in those regions where the prevailing fees program is approved by the local or state medical society."

In its report, the Board recalled a statement adopted by the House at the 1965 Annual Convention, which recommended that when government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care.

"Therefore, reimbursement for the services of physicians participating in government-supported programs should be on the basis of 'usual and customary' fees", the statement said.

Abortion and Sterilization

Recommendations for the enactment of legislation to legalize abortion and sterilization under certain conditions were referred to the Board for further study. This action was taken after the House had received a report from the Board containing the recommendations of the Committee on Human Reproduction.

The House suggested that the AMA can "render a distinct public service in this matter by conferring with other interested groups such as lawyers, clergy, sociologists, legislators, and government administrators."

It concurred in the reference committee's report that "it is not appropriate at this time for the AMA to recommend the enactment of legislation in this matter (abortion) for all states. The problem is essentially one for resolution by each state through action of its own legislature."

The report also stated that "it is true that there are medical implications in such legislative decisions; physicians in each state should freely provide information and guidance on these medical implications. However, enacting laws to integrate the medical aspects with the moral, ethical, religious, economic, social tradition, and other aspects of the problem is clearly the exclusive prerogative and the responsibility of the legislature of each separate state."

In its report the committee said the problems of sterilization "appear subject to the same general considerations as the problems of abortion."

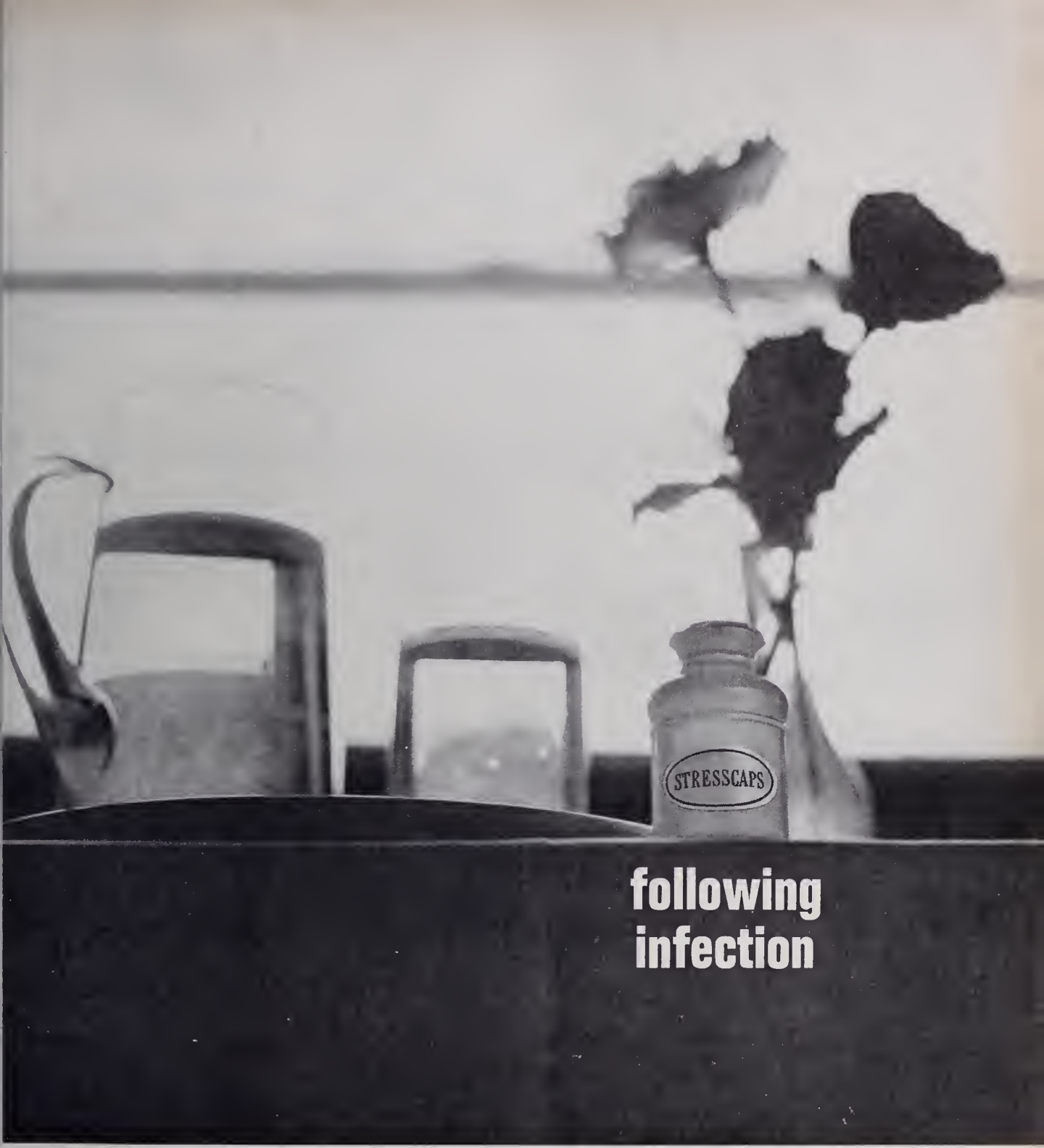
On the problem of contraception the House affirmed its 1964 policy statement that "the prescription of child-spacing measures should be available to all patients who require them, consistent with their creed and mores, whether they obtain their medical care through private physicians or tax or community-supported health services."

It also endorsed a statement that "appropriate legislation be enacted, wherever necessary, so that all physicians may legally give contraceptive information to their patients, consistent with the policy statement of December, 1964, and with the judgment and conscience of each individual physician."

Billing and Payment for Medical Services*

Eight statements on fees charged by physicians for medical services were affirmed by the House. These are applicable "irrespective of whether such fees are paid by the patient, or paid or reimbursed in whole or in part under Public Law 89-97, or any other third party plan," the House stated.

**NOTE: These statements are carried on the Insurance Page.* *See page 11.*



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A $25-a-year increase in membership dues, effective Jan. 1, 1967, was endorsed by the House when it was informed by the Board that additional income will be needed by then to avoid deficit spending.

The increase, to $70 a year for the AMA's 165,000 dues-paying members, will go before the House for final action at the 1966 Annual Convention because AMA Bylaws state that annual dues may be prescribed by the House only for the ensuing calendar year.

Board Chairman Percy E. Hopkins, M.D., told the House that "during 1964 and 1965, the AMA will have incurred an operating deficit of more than 1 million dollars." The budget for 1966, he said, is now narrowly in balance.

The 1966 budget calls for spending some 27.6 million dollars, Doctor Hopkins reported, including almost 10 million dollars on scientific programs, 5 million on health education and other medical service programs, more than 1 million to maintain physician records, and another million in the communication's program. Travel and meeting costs will exceed 2 million dollars.

Demand for Services Exceeds Income

"In a society," Doctor Hopkins said, "which has adopted inflation as a national policy and in which our system of medical care has become a pawn of politicians, it is not realistic to expect that we can limit tomorrow's programs to yesterday's income. Already demands are mounting from medical societies and physicians for a stronger and more effective AMA. These needs must be met and they must be adequately financed."

Doctor Hopkins said that AMA's income in 1960 was just under 16 million dollars, while in 1966 it will exceed 27 million, an increase of 11 million. "This represents increases of 3.9 million dollars from membership dues, 4.3 million in advertising revenue, and 2.8 million from other sources.

"During this same period," he stated, "the challenges thrust upon the Association required even greater expenditures—from 15.7 million dollars in 1960 to a need for 27.6 in 1966."

In support of the dues increase, the House noted that AMA's dues-paying members provide less than 30 per cent of the Association's income.

Gundersen Report

The House approved some of the many recommendations of the Committee to Review the Organization of the House (the Gundersen Committee) but it did not approve a number of others.

Here are the House actions on some of the committee's recommendations:

- *Size of the House of Delegates.* Approved the suggestion that the growth of the AMA House be slowed down after it reaches 250 members. When it reaches that size, the apportionment ratio will be automatically raised from one delegate per 1,000 members, or fraction thereof, to one delegate per 1,250 members, or fraction thereof, in electing further delegates to represent each state association.

- *Reports of Councils and Committees.* Rejected the proposal that reports of the Council on Medical Service and Medical Education be transmitted through the Board of Trustees before being presented to the House.

- *Reference Committees.* Adopted the recommendation that there be three reference committees by name—Amendments to Constitution and Bylaws, Credentials, and Rules and Order of Business—and as many others be appointed "as may be required to consider the items of business before the House."

- *Tenure of Subcommittee Members of Standing Committee.* Approved a change in the Bylaws "to limit to specified terms of one to three years the tenure of members of special committees of the councils and committees of the House, with a limitation of 10 consecutive years of service."

Federal Health Care Laws

The House took a number of actions with regard to federal health care laws passed in 1965, such as PL 89-97 (Medicare) and PL 89-239 (the Heart Disease, Cancer and Stroke Amendments). These actions included:

"That the AMA immediately seek remedial action to delete the requirement in Public Law 89-97 that a patient be hospitalized to establish eligibility for nursing home care."

"That the AMA immediately seek remedial action to amend Public Law 89-97, Part B, Title XVIII, by deleting the word 'receipted', from Section 1842-Part 3, Item B, line (ii), and substituting 'such payment will be made on the basis of a method of payment so arranged to preserve and continue the

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Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics ***in vitro***[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

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Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

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Indications: The bacterial spectrum includes: streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References**: 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science 1:185-256 (July-Aug.) 1964.

profession's current practice of billing.'" Also approved "that the AMA recommend that the Department of Health, Education and Welfare establish that an agreement for payment between the patient and physician constitutes valid evidence of services rendered."

Authorized a study of the constitutionality of PL 89-97 by calling on the Board to "take such action as may be necessary and appropriate to provide for the study and investigation of all aspects of PL 98-97 for the purpose of determining possible court action to test the legality and constitutionality of any provision or regulation issued under the law," and authorized the Board to "initiate such legal proceedings as it may deem advisable to implement the purpose and intent of this resolution."

Endorsed the Council on Medical Services' recommendation "that the state and local medical societies be urged *at this time* to assume leadership in the establishment of local advisory committees" under the Heart Disease, Cancer and Stroke Amendments of 1965. The House noted that a National Advisory Council under PL 89-239 already has been appointed by federal officials and that the AMA was not given an opportunity to recommend possible appointees to the Council. "Therefore," the House declared, "active physician participation at the state and local levels is of utmost importance."

Urged HEW to "seek consultation with practicing physicians" in formulating regulations under Title XIX as has been done under Title XVIII of the medicare law. It also instructed the AMA President and AMA Advisory Committee to HEW to "offer and urge such consultation."

Adopted a resolution that the Board "continue to seek, through all appropriate means, the implementation and administration of federal medical and health programs other then those of the Armed Forces and Veterans' Administration by the Surgeon General of the Public Health Service, and especially those programs under Title XIX of PL 89-97."

Declared that the AMA Advisory Committee on PL 89-97 and 89-239 should persist in its efforts to achieve "practical recognition" by HEW of the differences between utilization review and claims review function". It also adopted a series of recommendations in the report aimed at clearing the confusion.

WANTED—INTERNIST, Board Eligible or Certified. To be associated with twelve man specialty group; Salary open; No investment; Early partnership; Progressive city of 35,000 in central Texas.

Write J. D. Wilson, M.D.
King's Daughters Clinic
Temple, Texas

A study committee to evaluate planning techniques and development, which was established by the Board of Trustees, was concurred in by the House. The committee was given the tasks of (1) reviewing and studying current planning procedures in AMA, and (2) studying and recommending new mechanisms for organizational arrangements to achieve more effective planning and development in the future. Membership on the committee includes five Board members, the chairmen of the Councils on Medical Service, Medical Education, and Legislative Activities, the Speaker of the House, and two House members selected by the Speaker.

Disapproval was expressed by the House of portions of the Coggeshall report, "Planning for Medical Progress Through Education," published earlier this year by the Association of American Medical Colleges. The House opposed "the basic philosophy" of portions of the report; such as:

That the AAMC should "serve as spokesman for organizations concerned with education for health and medical sciences" and "no other organization is in a comparable position to bring together and express a comprehensive view."

That "the professional aspects of education for health and medical sciences should be regarded as an essential function and fully integrated component of university organizations, with decreasing dependence upon or control by organized professions and their related associations."

Aid to Federal Education

A policy statement on federal aid to medical education was adopted by the House. It urges that (1) a major objective of the policies of the AMA should be to place the control of the full range of medical school functions in their institutional governing bodies, (2) action of the AMA should be designed to achieve this objective by proposal of appropriate legislation, and (3) the AMA should foster diverse sources of support for medical schools under circumstances that prevent any extramural source from exercising controlling influence.

The House approved a resolution aimed at responding immediately at the national and local levels to statements discrediting medicine. It directed the Board to provide for such response by the AMA and encouraged state and local medical societies to react similarly to statements appearing at the local level and concerning matters within the society's competence and knowledge.

There were scores of other actions by House. Briefly here are some of them:

- Approved a resolution calling for continued efforts, through "all appropriate channels," to achieve a separation of billing and payments for professional fees from hospital charges under insurance contracts written by the health insurance industry.
- Urged the American Hospital Association to "assist the hospitals of the U.S. to establish a system of uniform cost accounting and billing."
- Asked that all colleges and universities should have health education programs for their students.
- Commercial physicians in government service



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(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

for "their support of the medical profession and their service to the public."

• Agreed to a re-writing of two sections of a model agreement between hospitals and physicians providing professional services in hospital emergency departments to conform to principles established by the House.

• Approved measures aimed at decreasing substantially the perinatal death rate through perinatal study committees in hospitals.

• Requested state medical associations to act to assure that physicians are properly represented on state Hill-Burton hospital advisory councils.

• Asked the Federal Aviation Agency to change its regulations so that any person applying for a pilot's license would be giving his implied consent to sobriety examinations by aviation officials.

AMA Commends Arthur Hess

• Adopted a statement by Edward R. Annis, M.D., commending Arthur Hess, the director of the Social Security Administration's Bureau of Health Insurance, for his "wholehearted cooperation" with the AMA's Advisory and technical committees on medicare.

• Instructed the Council on Medical Service and its Committee on Welfare Services to develop for the AMA its definition and principles for the determination of medical indigency.

• Accepted for information an opinion adopted jointly by the Council on Medical Service and the Judicial Council which states that ". . . when a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction and supervision."

• Repeated a previous policy statement urging the creation of a separate post in the Cabinet of the President of the U.S. for a Secretary of Health.

• Commended past president Edward R. Annis, M.D., for his leadership, his dedication, and his tremendous contribution to medicine's campaign to preserve the world's finest system of medical care."

• Approved the following AMA conventions:

Annual Conventions—1966, Chicago; 1967, Atlantic City; 1968, San Francisco; 1969, New York City; 1970, Chicago.

Clinical Conventions—1966, Las Vegas; 1967, Houston; 1968, Miami Beach; 1969, Denver; 1970, Boston.

Excellent opportunity for GENERAL PRACTITIONER in community of 15,000; central Florida; 76 bed JCAH Hospital. Write or call collect R. C. Thompson, BARTOW MEMORIAL HOSPITAL, BARTOW, FLORIDA

Sixteen Speciality Groups Plan To Meet at Annual Meeting

Sixteen specialty groups will participate in the 1966 KMA Annual Meeting which will be held September 20-22 at the Convention Center in Louisville. Specialty group participation in the KMA Annual Meeting was first initiated eleven years ago.

A meeting of the specialty group presidents and representatives of the KMA Council on Scientific Assembly and Scientific Program Committee was held at the KMA Headquarters Office in Louisville on Thursday, December 16 to plan the role of the specialty groups in this year's meeting.

"The cooperative effort by the KMA and specialty groups permits outstanding talent to be brought to the meeting and provides in depth discussions at specialty group meetings while also assuring a general sessions program of interest to all KMA members," said KMA President, Everett H. Baker, M.D., Louisville.

Nationally known speakers will be invited by the specialty groups to appear on the Annual Meeting general sessions program in addition to the program of the specialty groups. Closed circuit color TV, which will be featured at the 1966 Annual Meeting, will be used both during the general sessions and by two of the specialty groups.

Three Ky. Physicians to Chair SMA Specialty Sections

Three Kentucky physicians have been named to head their respective specialty sections within the Southern Medical Association, according to an SMA news release.

W. Vinson Pierce, M.D., Covington, will serve as chairman for the coming year of the Section on Urology. Andrew M. Moore, M.D., Lexington, has been chosen as chairman of the Section on Plastic and Reconstructive Surgery.

Douglas M. Haynes, M.D., chairman of the department of obstetrics and gynecology at the University of Louisville School of Medicine, was named chairman-elect of the Section on Obstetrics and will take office next year at this time.

AMA-ERF Receives Contributions

Contributions totaling more than $463,000 were presented to the American Medical Association Education and Research Foundation during the November 29 session of the American Medical Association House of Delegates at the AMA's Philadelphia meeting.

These contributions were: $203,655 from the California Medical Association; $189,000 from the Illinois State Medical Society; $45,000 from the New Mexico Medical Society; $15,610 from the Utah State Medical Association; $9,605 from the Medical and Chirurgical Faculty of Maryland; and $510 from the Woman's Auxiliary to the Clackamas County, Oregon, Medical Society.



more complete relief for the "dyspeptic"

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Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

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The new Rehabilitation Center, 220 East Madison, Louisville, has spacious modern facilities for use by Kentucky physicians and their physically handicapped patients. The new Center was opened in August of last year.

Physicians From Throughout State May Refer Patients To New Rehabilitation Center in Louisville

The new Rehabilitation Center in Louisville—called the most comprehensive facility for the treatment of the physically handicapped in Kentucky—opened its doors in August, 1965. The Center receives its patients by referral from practicing physicians.

Located at 220 East Madison, in the Medical Center, the spacious, modern facility represents a giant step in the expansion of services to the physically handicapped. Since 1954, the Center had been located in cramped rented quarters at General Hospital.

With space for 30 inpatients and 75 outpatients, the attractive three level building houses a staff of more than 50 and $250,000 worth of the very latest equipment. Its primary purpose is, through treatment and instruction, to help the handicapped to function at their highest possible performance level and to aid in the diagnosis of neuromuscular disease.

All treatment and clinical work are under the direction of Medical Director Robert M. Izard, Jr., M.D. A graduate of Baylor University College of Medicine, Doctor Izard is board certified in physical medicine and rehabilitation and was formerly head of that department at Veterans Hospital in Lexington.

With maximum rehabilitation of the individual patient as their aim, 10 departments coordinate their services in a team approach which Doctor Izard cites as one of the Center's prime advantages.

Services include: a medical department (with one full and one part-time physician), nursing service, physical therapy, occupational therapy (including training for activities of daily living), recreation therapy, speech therapy, postlaryngectomy voice training, medical social service, psychological counseling and testing, and a prosthetic clinic. Twice weekly, panel discussions are held in which all disciplines evaluate individual patient progress.

"Full utilization of the Center is one of our goals," Doctor Izard said. Early in December, 13 of the 30 beds were filled.

Service to physicians and their patients is the basic reasons for the Center's existence. Patients are accepted on the basis of physician referral. Referrals are made directly to Doctor Izard with the referring physician usually continuing the treatment of his patient's other medical needs. Should a doctor wish to refer his case to another physician, this M.D. may then handle the referral and work with the Center on the case.

There is no limit to the geographical area served by the Center and often patients come from Ohio and Indiana as well as from throughout Kentucky. According to Doctor Izard, most of the patients are "private pay" referrals, but some are sponsored by agencies.

A non-profit organization, the Rehabilitation Center was first established in Louisville in 1954. Its Medical Advisory Council and its Board of Directors serve without pay. Even when it was first established in its former quarters, plans were being made for today's spacious, new facility.

The new building, financed through a public fund drive in 1962 and Hill-Burton funds, is dedicated to Mrs. Amelia Brown Frazier. Mrs. Frazier, a former patient, was a leader in the fund drive and one of the founders.

The institution serves patients of all ages with a variety of disabilities such as burns, amputations,

(Continued on Page 82)

the price of "success"



Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

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EACH SCORED TABLET CONTAINS:
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In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

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NEWS ITEMS

Fitzhugh Mullins, M.D., has become associated with **Condict Moore, M.D.,** at Louisville, where his practice will be limited to general surgery. Doctor Mullins came to Louisville from Bethesda, Md., where he was a member of the senior staff of the National Cancer Institute of the National Institutes of Health. He was graduated in 1956 from the Medical College of Virginia.

George F. Berry, M.D., has started general practice at Lancaster where he is associated with the Garrard Clinic. A 1962 graduate of the University of Louisville School of Medicine, Doctor Berry interned at St. Joseph Infirmary in Louisville. He recently completed two years of service in the U.S. Navy.

Ward O. Griffen, Jr., M.D., has joined the fulltime teaching staff of the University of Kentucky Medical Center in general and thoracic surgery. A 1953 graduate of the Cornell University Medical College, his postgraduate training was completed at Bellevue Hospital and the University of Minnesota Hospitals. He came to Lexington from a post on the faculty of the University of Minnesota Medical School.

Sidney W. Winchell, M.D., an anesthesiologist, is now in practice in Louisville, it was recently announced. Doctor Winchell was graduated in 1956 from Hahnemann Medical College and interned at St. Luke's Hospital, Bethlehem, Pa., before completing his residency at Columbia Presbyterian Medical Center. He previously served as an instructor of anesthesiology at the University of Pittsburgh Medical School.

Keith E. Ellis, M.D., a general practitioner, is now in practice at Benton, where he is associated with **H. W. Ford, M.D.** Doctor Ellis, who graduated in 1962 from the University of Louisville School of Medicine, interned at the Medical Center, Columbus, Ga. Prior to beginning his practice at Benton, Doctor Ellis served for two years in the U.S. Air Force.

Luther W. Pearce, M.D., a psychiatrist, has joined the staff of the Louisville Area Mental Health Center at Norton Infirmary, where he will practice in association with **Warren M. Cox, M.D.** A 1955 graduate of the Albany Medical College, he interned at Cincinnati General Hospital and completed his postgraduate training at Walter Reed Medical Center.

Harry G. Caldwell, M.D., is now associated with the Lexington Clinic, where his practice will be limited to ophthalmology, it has been announced. Doctor Caldwell, who recently completed a year on the Bunker Fellowship in corneal surgery at St. John Ophthalmic Hospital, Jerusalem, Jordan, graduated in 1958 from the University of Louisville School of Medicine. He interned at Jackson Memorial Hospital, Miami, and completed his residency training at U. of L.

Robert D. Milledge, M.D., has joined the faculty of the University of Kentucky department of radiology. Doctor Milledge, a 1957 graduate of Emory University School of Medicine, took his postgraduate training at the University of Alabama Medical Center and the Veterans Hospital in Atlanta. He came to Lexington from the University of Arkansas.

Samuel W. Gehring, M.D., has become associated with **Robert Fidler, M.D.,** at Flemingsburg. Doctor Gehring, a general practitioner, was graduated in 1962 from the University of Louisville School of Medicine and interned at St. Joseph Infirmary in Louisville. He has just completed two years of service with the U.S. Air Force.

Paul L. Odom, M.D., has opened an office at Elkhorn City for the practice of general medicine, it was recently announced. Doctor Odom, who graduated from the University of Mississippi School of Medicine in 1963, interned at Mobile General Hospital, and was in practice for a short time at Bay St. Louis, Miss.

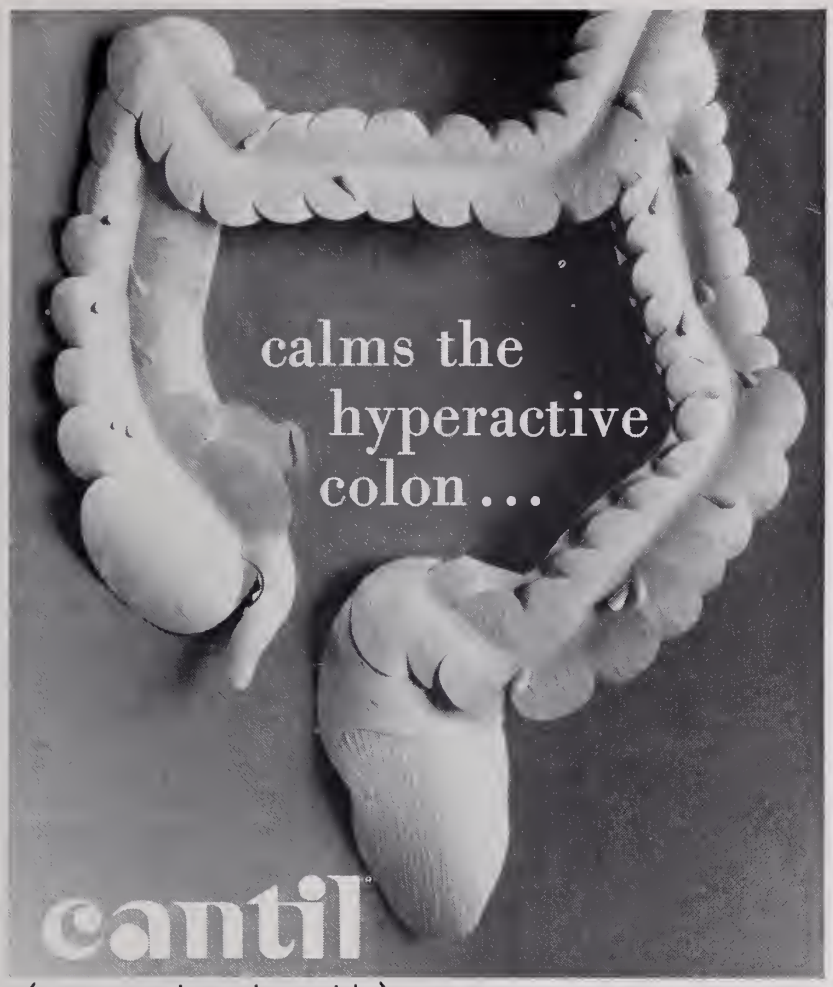
Robert S. Davis, M.D., has become associated with the Daniel Boone Clinic at Harlan, according to a recent announcement. A general practitioner, Doctor Davis graduated in 1964 from the University of Louisville School of Medicine and interned at St. Joseph Infirmary, Louisville.

Mehmet S. Akaydin, M.D., has joined the staff of the Veterans Administration Hospital in Lexington. A psychiatrist, Doctor Akaydin received his M.D. degree from Istanbul University and interned at St. Lukes Hospital, Newburgh, N.Y. His residency training was taken at Warren State Hospital, Warren, Pa., and Danville State Hospital, Danville, Pa. He formerly served as director of the State Psychiatric Clinic at Jameston, N. Dak.

Susan J. Brenner, M.D., has started the practice of internal medicine at McDowell, where she is associated with the Daniel Boone Clinic. Doctor Brenner was graduated in 1959 from the University of Pennsylvania School of Medicine and interned at Robert Packer Hospital, Sayre, Pa. Her postgraduate training was taken at Bernalillo County Indian Hospital, Albuquerque, N. Mex.

James F. Kurfees, M.D., has opened an office at Crestwood, where he will limit his practice to internal medicine. Doctor Kurfees was graduated in 1956 from the University of Louisville School of Medicine. Following a residency in general practice at Macon, Ga., he was awarded a post-doctoral research fellowship in medical physiology at the University of Alabama, where he was a visiting lecturer in physiology in 1964.

Vernon C. Scandrett, M.D., a general practitioner and former medical missionary in Columbia, South America, is now practicing in association with the Daniel Boone Clinic at McDowell. Doctor Scandrett received his medical degree from the University of Illinois in 1949, and interned at Cook County Hospital, Chicago.



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"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

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CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Milwaukee, Wisconsin 53201

nerve injuries, muscular dystrophy, multiple sclerosis, arthritis, cardiovascular diseases, strokes, cord injuries, and others.

Doctors having patients who could be improved by rehabilitation are urged to make use of the Center. Ideally equipped to meet the needs of the handicapped, its patient areas are bright and cheerful and its equipment extensive and up-to-date.

Equipment was obtained through the Center building fund, grants, and contributions from individuals, civic organizations, and business firms. The postlaryngectomy voice department was initiated by the Kentucky Chapter, American Cancer Society which continues an annual grant for this purpose.

Designed for expansion upward by two more stories, the building was planned to keep pace with the demands of the future. KMA members are invited to visit the Center to see the expanded facilities for treatment of the physically handicapped.

COUNTY SOCIETY REPORTS

McCracken

David Neustadt, M.D., professor of medicine at the University of Louisville School of Medicine, was the principal speaker on the scientific program at the regular monthly meeting of the McCracken County Medical Society October 20 at Boswell's Restaurant in Paducah.

Doctor Neustadt spoke on the "Physical Features in Common Rheumatic Disorders", a talk illustrated with slides.

Following the scientific session, the business meeting was held, presided over by Joseph Spaulding, M.D., president.

Among business matters brought up at the meeting was the report of the chairman of the Legislative Committee, William Myre, M.D., on the proposed change in the Society Bylaws regarding the provisional status of new members. The committee proposed that the change be decided by the Society as a whole. It was therefore directed by the president that the secretary compose a letter describing the "Orientation Course", and the provisional status of new members, to be sent to members for their information. Action will then be taken at the next meeting.

Doctor Myre also reported on the use of promotional aids and planning guides for Community Health Week, set for November 7-13 this year. The motion was made and seconded that the Society take no part in such a promotional program. The motion passed unanimously.

The Society than heard the report of the county delegates to KMA. R. M. Wooldridge, M.D., reported that no special action was taken by the delegates. He mentioned a great deal of discussion of PL 89-97 (medicare), which will be instituted next year. Doctor Wooldridge reported that J. R. Miller, M.D., Benton, was elected trustee from the district as recommended by the Society at the last meeting.

In discussing new business, Eli Khouri, M.D., introduced a motion that the Society go on record as endorsing the local Sewer Bond Issue purely on the basis of medical and public health benefits. After discussion, the motion was seconded and carried.

The meeting was adjourned at 9:30 p.m.

NEWS ITEMS

John D. Fielding, M.D., a 1962 graduate of the University of Louisville School of Medicine, has opened an office at Warsaw for the general practice of medicine. Doctor Fielding, who interned at St. Elizabeth Hospital, Dayton, O., recently completed two years of service in the U.S. Air Force.

Michael G. Kemper, M.D., has begun general practice at Louisville, it was recently announced. Doctor Kemper, who was graduated in 1962 from the University of Louisville School of Medicine, interned at Louisville General Hospital. He was recently discharged from the U.S. Air Force with the rank of Captain.

In Memoriam

WILLIAM JOSEPH MARTIN, JR., M.D.
(Formerly) Louisville, Ky.
1900-1965

William J. Martin, Jr., M.D., 65, who practiced in Louisville since 1932 died December 10 at Rochester, Minn., where he had been hospitalized for several days. He retired from the practice of proctologic surgery in 1963, and had lived in Russellville since early 1965. He was graduated in 1927 from the University of Pennsylvania School of Medicine.

Ruptured Aortic Aneurysm

(Continued from Page 51)

resection of a ruptured abdominal aortic aneurysm with restoration of continuity by insertion of a dacron prosthesis. Relatively early operative intervention and a reasonably normal physiologic pre-operative state were probably responsible in considerable measure for the successful outcome.

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KMA Council and Committee Reports

Council on Scientific Assembly

Everett H. Baker, M.D., Louisville, Chairman

KMA Headquarters Office **October 28, 1965**

The Council on Scientific Assembly met soon after the 1965 Annual Meeting to plan the Annual Session scheduled for September 20-22, 1966.

General plans for all business and scientific activities associated with the annual meeting were outlined for 1966 and the details for all scientific sessions were referred to the Scientific Program Committee. Requests from allied groups to schedule functions during the 1966 Annual Meeting were considered and times assigned for such activities were made as felt appropriate by the council members.

It was taken by consent that the 1966 Annual Meeting again be held at the Convention Center in Louisville with the Kentucky Hotel being the headquarters hotel.

Scientific Program Committee

Roderick Macdonald, Jr., M.D., Louisville, Chairman

KMA Headquarters Office **November 24, 1965**

The KMA Scientific Program Committee met early in the associational year to plan the scientific sessions for the 1966 KMA Annual Meeting September 20-22. General sessions were planned for Tuesday morning, all day Wednesday, and Thursday morning. Specialty groups were scheduled to have sessions on Tuesday and Thursday afternoons.

The committee members agreed to present four half-hour programs of closed-circuit color TV during the general sessions at next year's meeting and expressed appreciation to Smith, Kline and French Laboratories who will sponsor the color TV presentations. Themes for each half-day session were approved by the committee members.

Council on Medical Education and Hospitals

George A. Selzlinger, M.D., Louisville, Chairman

KMA Headquarters Office **December 2, 1965**

The Council on Medical Education and Hospitals held their organizational meeting for this associational year, reviewed its activities for the past year, and discussed the plans of the various committees serving under the council.

Plans for a meeting of representatives of KMA and Kentucky's two medical schools were considered and a report on the Postgraduate Fund was accepted by the council members who urged that monies from the fund be expended for scientific purposes associated with the Annual Meetings of KMA. Numerous actions of the AMA House of Delegates of interest to the council were acted upon.

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

KMA Headquarters Office **November 13, 1965**

The KMA Hospital Committee met on November 18 and devoted most of its attention to Resolution A, passed by the KMA House of Delegates in September 1965 and which pertained to administrative relationship between hospitals and private practitioners of medicine practicing within hospitals.

Members of the committee discussed area-wide planning and expansion of the Hospital Dry-Run Teams. It was recommended that additional teams be formed since numerous hospitals are requesting accreditation by the Joint Commission on Accreditation.

The committee is scheduled to meet again on January 27 at which time further discussion will be held on Resolution A and recommendations made concerning there being a special appointed sub-committee of the Hospital Committee.

KMA Council on Legislative Activities

John C. Quertermous, M.D., Chairman, National Affairs

J. Campbell Cantrill, M.D., Georgetown, Chairman, State Affairs

KMA Headquarters Office **November 9 and 10, 1965**

Consideration was given to proposed legislation in the 1966 Kentucky General Assembly, which would be of interest to the profession. Plans were finalized on the KMA Legislative Key Man System, and the Orientation Program for all key men, to be held on January 12, 1966, at the Brown Suburban Motel, Louisville.

The Council viewed the slide presentation prepared by the AMA Committee on Quackery, under the direction of Joseph A. Sabatier, Jr., M.D. An annual Report by the Ad Hoc Committee to Study Cults was presented.

The Kentucky Nurses Association met jointly with the Council on Legislative Activities to discuss items of mutual interest.

All Congressional District Key Men were invited to attend this meeting.

Council on Medical Services

John A. Bishop, M.D., Jeffersontown, Chairman

KMA Headquarters Office **November 18, 1965**

The Council on Medical Services acted upon a number of referrals from the KMA Executive Committee and assigned specific matters to the committees serving under the council at their recent meeting.

Public Law 89-97 (the "Medicare" law), Medical Assistance to the Aged, and Public Assistance to the

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ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

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Aged were discussed at some length by the council members. Programs for the council's committees were reviewed and times were approved for numerous committee meetings. A recommendation was made to change the name of the Medicare Review Committee to Dependents Medical Care Review Committee. The council members set their final meeting date for June 9, 1966.

Governmental Medical Services Committee

L. Douglas Atherton, M.D., Louisville, Chairman

KMA Headquarters Office **December 2, 1965**

The Governmental Medical Services Committee at its first meeting of the associational year had guests from the Veterans Administration and Kentucky Physicians Mutual, Inc., to discuss the Dependents' Medical Care Contract and the VA Hometown Medicare Contract. At the December 2 meeting, the committee recommended that the KMA Journal devote space to briefly explain these two contracts.

Various governmental health programs affecting Kentucky physicians were discussed and members of the committee briefly reviewed the summary of medical legislation passed by the first session of the 89th Congress. Another meeting of the committee is planned in the near future.

In The Books

(Continued from Page 32)

or capable. Dr. Mary S. Calderone, an authority in this field, created much consternation in the past by suggesting that most doctors claiming proficiency in this sphere were, in fact, intellectual virgins.

Physiologic foundations for marriage counseling offers an interesting and unusual approach. A lucid explanation of the physiology of human reproduction, of genetics and developmental defects proffers a substantial framework for the inquiring physician. The homey, commonsense observations on the emotional aspects of marriage are a delight to read. All references are reviewed in a few, no-nonsense sentences. The suggested premarital examination is so elaborate, however, that few physicians will feel the entire routine either practicable or necessary. The author is an associate professor of physiology and medicine and director of health services at the University of Oregon. Dr. Trainer deserves substantial credit for this valient effort but one person simply cannot satisfactorily explain all facets of so complex a topic. His strong and weak points are sharply demarcated. A well-rounded understanding of marriage defies a single viewpoint.

But despite their rueful origins, books of sex instruction are beginning to show maturity and worth. The publication of personal reminiscences or testimonials or vivid case reports are no longer the only source of sex information. This most sensitive field takes on structure and perspective through an objective approach. Despite its imperfections, this book is a move forward.

HOMER B. MARTIN, M.D.

Committee on Disaster Medical Care

William T. Rumage, Jr., M.D., Louisville, Chairman

KMA Headquarters Office **November 11, 1965**

The KMA Disaster Medical Care Committee at its last meeting discussed Packaged Disaster Hospitals, staff assignments, medical self-help courses sponsored by doctors, community disaster plans and exercises, hospital radio networks, and a survey on ambulances and ambulance drivers' first aid training.

Guests from the Kentucky Dental Association, U. of K., U. of L., Fort Knox, and the Department of Health, attended and contributed to the meeting. The committee members approved a resolution pertaining to the erection of hospital signs on major highways to the AMA House of Delegates for consideration at the AMA Clinical Meeting. The next committee meeting was scheduled for February 10, 1966.

Public Health Page

(Continued from Page 18)

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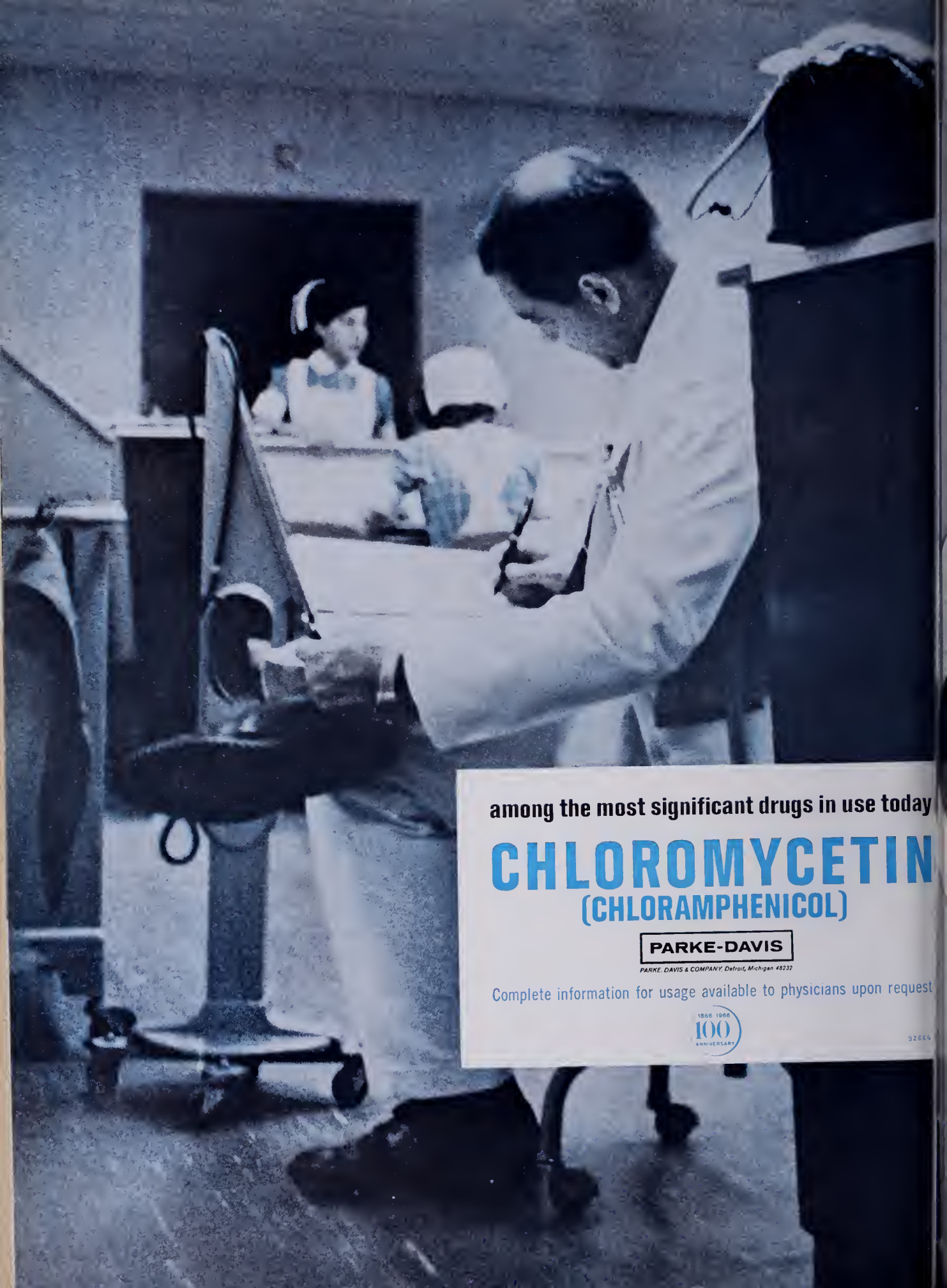
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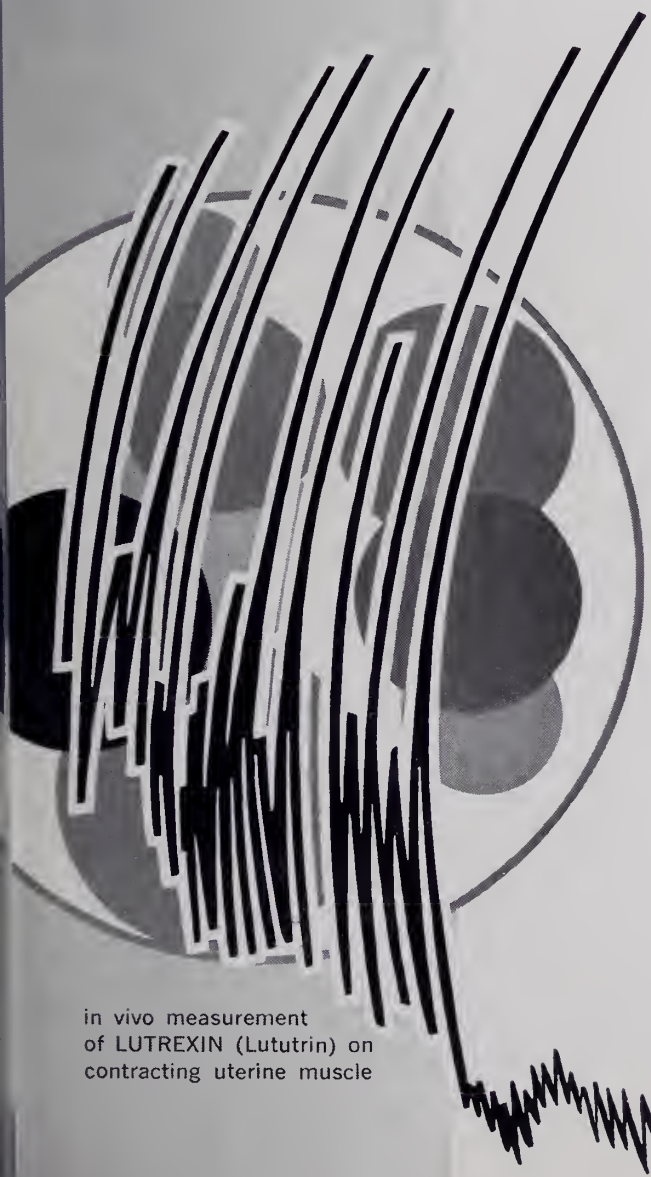
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Neo-Synephrine is a standard among topical vasoconstrictors. It is unsurpassed for reducing nasal turgescence in colds; and a most valuable aid in preventing and treating sinusitis.

Neo-Synephrine stops the boggy feeling of colds at once—works against factors that induce sinusitis. With Neo-Synephrine nose drops, spray or jelly, turbinates shrink on contact, obstructed ostia open and drainage is re-established.

In sinusitis, Neo-Synephrine helps to promote drainage and hasten recovery.* Used promptly, it helps clear the stagnant sinus and lessen the chances of chronicity.

Neo-Synephrine HCl is available in:
⅛% solution for infants
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¼% pediatric nasal spray for children
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½% jelly for children and adults
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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In colds and sinusitis

Neo-Synephrine® HCl

(brand of phenylephrine hydrochloride)

solutions/sprays/jelly

MESSAGE FROM THE PRESIDENT



Interim Meeting

WEDNESDAY evening, April 13, and Thursday morning, April 14, should be underlined on our calendar now. These are the dates of our annual Interim Meeting at DuPont Lodge, Cumberland Falls, near Corbin. Much time and thought has been given to the program.

Following the dinner Wednesday, April 13, there will be a panel discussion on the operation of the Admission and Review Committees. The panelists will be G. W. Slagle, M.D., of the A.M.A.; Philip Lee, M.D., of the Social Security Administration; Mr. Wade Mountz, past president of the Kentucky Hospital Association; and Mr. Avil McKinney, director of Physician-Hospital Relations for Blue Shield-Blue Cross. Their presentation, plus a question and answer period, should be interesting and informative.

The meeting concludes Thursday noon with a luncheon, at which James Z. Appel, M.D., president of the A.M.A., will speak.

July 1, 1966 is the date that Medicare becomes a reality in our lives. Physicians and hospitals will come face to face with a new challenge overnight. What will unfold in the last half of the year is impossible to anticipate, but the use of available information, equanimity, and courage will serve us well.

It will be a time when the true need of every patient and the utilization of facilities and beds will bring physicians and other members of the "healing arts" closer together than ever before.

Winston Churchill so ably said, "If Britain survives a thousand years men will say, 'This was their finest hour'." The hour of medicine is now.

Everett H. Baker

to help relieve pain in common anorectal disorders

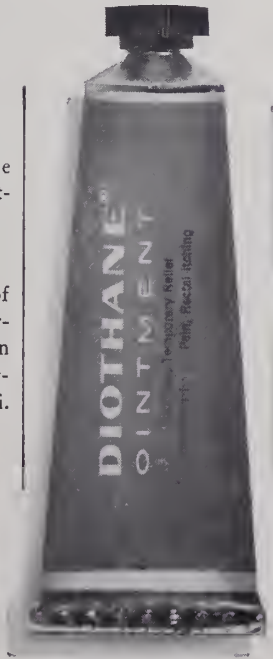
"non-caine" Diothane®

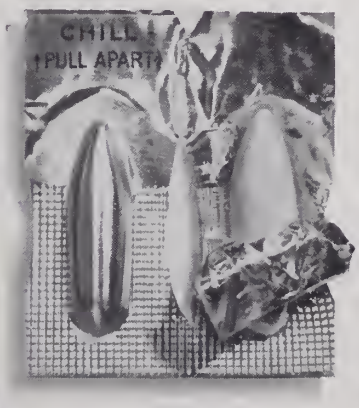
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





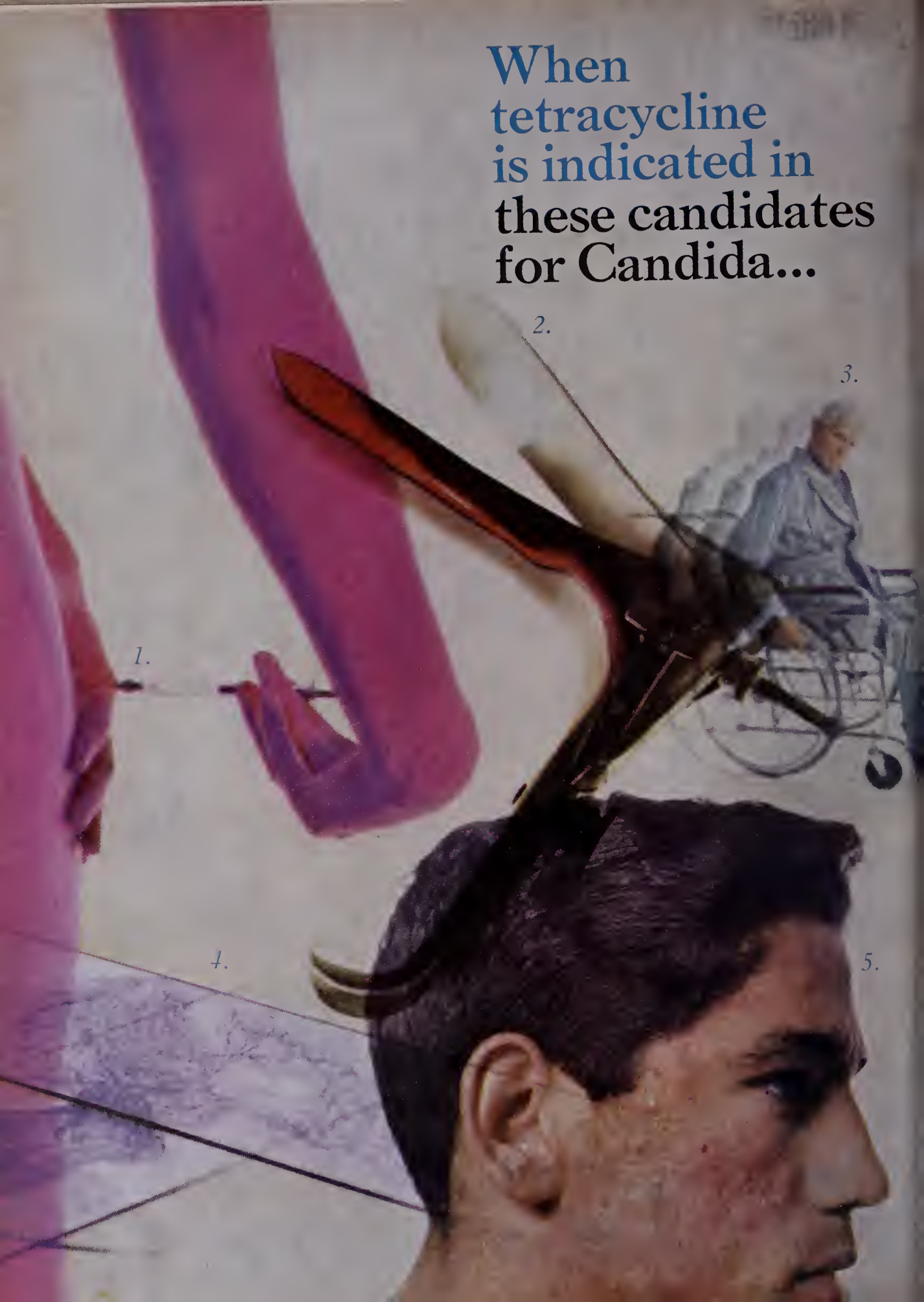
DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

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When
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is indicated in
these candidates
for Candida...
1.
2.
3.
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5.

New low-cost tetracycline/ antifungal therapy

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tetracycline phosphate complex –nystatin

Because new Tetrex-F (tetracycline phosphate complex-nystatin) is the most economical therapy of its kind that you can prescribe, it is a sound choice whenever tetracycline therapy is indicated in patients predisposed to monilial infections.

Who are these "candidates for Candida"?

1. diabetic patients
2. nonpregnant women with a history of recent or recurrent monilial vaginitis
3. elderly or debilitated patients
4. patients with a past history of moniliasis
5. patients on long-term tetracycline or corticosteroid therapy.

For these patients, Tetrex-F (tetracycline phosphate complex-nystatin) provides efficient tetracycline therapy against a broad range of infections *plus* protection against superinfection associated with the overgrowth of *C. albicans* in the G.I. tract.

Priced for savings

Tetrex-F (tetracycline phosphate complex-nystatin) is lowest in cost—priced 20% lower than most tetracycline/antifungal products.

BRISTOL THERAPEUTIC SUMMARY

For complete information consult Official Package Circular.

Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.

Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dosage: 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.

Supply: Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. Oral Suspension, 60-ml. bottle. Each 5 ml. contains tetracycline equivalent to 125 mg. tetracycline hydrochloride and nystatin, 125,000 units.

BRISTOL

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Division of Bristol-Myers Co.
Syracuse, New York

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials—usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

Indications: Diarrhea. *Contraindications:* Kaolin: Withhold if diverticulosis is present or suspected. *Precautions:* Sulfonamide: Continued use requires supplementary administration of thiamine and vita-

your Rx for Cremomycin can provide relief



min K. Neomycin: Patient should be observed for new infections due to bacteria or fungi. *Side Effects:* Sulfonamide: Sensitivity reactions may occur (e.g., skin rashes, anemia, polyneuritis, fever; agranulocytosis with a fatal outcome has been reported). Reduction of thiamine output in the feces and of vitamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.
Before prescribing or administering, read product circular with package or available on request.

promptly relieves diarrheal distress

Cremomycin®

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

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where today's theory is tomorrow's therapy



Answers to Questions About Your Blue Shield

QUESTION: What are the responsibilities of the Blue Shield Medical Advisory Committee?

ANSWER:
(a) Proper administration of the Blue Shield Contract.
(b) Reviewing cases which are not listed in the Schedule of Indemnities and establishing fees to be allowed.
(c) Mediating any type of dispute which may arise between participating physicians and the Plan, and serving as liaison between participating physicians and the Plan in instances of any administrative dissatisfaction.
(d) Carefully evaluating the schedule of benefits with a view to recommending adjustments to the Board of Directors, from time to time, in order to increase the scope of service as conditions permit and the need is determined.
(e) Supervising benefit disbursement of Plan funds.
(f) Reporting physician and subscriber complaints or dissatisfaction to the Board of Directors.

QUESTION: Does Blue Cross authorize payment of Blue Shield claims?

ANSWER: *No. Authorization for payment of claims is solely a Blue Shield function.*

QUESTION: Who is eligible to apply for Blue Shield on a non-group basis?

ANSWER: *People living in Kentucky who are 64 years of age or under, in good health, and if neither applicant nor spouse is employed where there are 10 or more persons.*

QUESTION: How can my secretary learn to read Blue Shield coverage codes on identification cards?

ANSWER: *She will find an explanation of the codes on page XII through XVII in the Participating Physicians' Manual, Schedules C and D. Upon request, a representative of the Blue Shield Professional Relations staff will assist your secretary in code identification procedures.*

QUESTION: What is considered a "medical service"?

ANSWER: *Medical service shall be defined as services which do not involve:*
(a) Operative or cutting procedures for the treatment of disease or injury,
(b) Treatment of fractures, dislocations, or other accidental injury,
(c) Obstetrical procedures including pre-natal or post-natal care,
(d) Radiation Therapy.

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pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



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New **EUTRON** extends your range of treatment in moderate to severe hypertension



A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

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Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
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Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

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PRINCIPLES OF CHEST ROENTGENOLOGY — A PROGRAMED TEXT: by Benjamin Felson, M.D., Aaron S. Weinstein, M.D., and Harold B. Spitz, M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1965; 221 Pages; Price $6.00.

This soft covered book, a programed text, is directed towards the non-radiologist who deals with chest-x-rays. The material presented is based on Doctor Felson's recent excellent text, *Fundamentals of Chest Roentgenology*.

The programing is direct, self-explanatory, and stresses the basic fundamentals of chest x-ray analysis, which unfortunately many physicians who have "read" chest films for many years do not know. The program consists of blanks to be filled in by the reader and the answer is immediately available on the right hand column. The latter may be covered by a strip of paper before reviewing the answer.

The material leads from the techniques of the examination, through lobar and segmental anatomy, to the silhouette and air bronchogram signs, and on to segmental and lobar collapse. The pleural and extra-pleural spaces complete the program.

There is perhaps too much stress on segmental anatomy for the beginner, particularly with the inclusion of Boyden's numbering system. Those familiar with Doctor Felson's humor will not be disappointed as they study the material.

This text is strongly recommended for medical students and physicians who must be familiar with chest films. Many "old-timers" will be amazed at some of the revelations to be seen on the ordinary chest film after completing this programed text.

LAWRENCE A. DAVIS. M.D.

PEDIATRIC ELECTROCARDIOGRAPHY: by Warren G. Guntheroth, M.D.; Published by The W. B. Saunders Company, Philadelphia and London, 1965; 150 Pages; Price, $7.00.

In the preface the author states "the goal of this monograph is to provide an accurate but brief introduction to an approach to electrocardiography, with emphasis on pediatric experience." This goal has been faithfully sustained in the 150 page book.

The outlay of the book is logical and clear beginning with general principles of electrocardiography all the way through discussion of normal and abnormal electrocardiograms in the pediatric age group. The vector approach is used throughout with remarkable simplicity and directness creating a very close relationship between the scalar and the vector systems.

The illustrations are plentiful and at the same time purposeful giving a sufficient range of variations within a given problem.

Whereas all the chapters are extremely well-written, the chapters on Disorders of Rate, Mechanism and Rhythm and Disorders of the Sequence of Excitation excel in lucidity of statement combined with brevity of content.

In the reviewer's opinion the book represents an excellent statement of the goals of the author.

KAREEM MINHAS, M.D.

MANAGEMENT OF THE PATIENT WITH CANCER: Edited by Thomas F. Nealon, Jr., M.D.; Published by the W. B. Saunders Company, Philadelphia and London, 1965; 1039 Pages; Price, $27.50.

The need for an up-to-date, comprehensive, one-volume book on cancer has long been apparent. This 1000 page volume, written by 71 contributors, succinctly describes the most popular management of the great majority of malignant tumors. Exhaustive cataloguing of alternative methods of treatment was deliberately and fortunately omitted.

A deficiency of considerable magnitude exists, however, when well established alternative methods of treatment with clear-cut indications for their use are hardly mentioned. Such is the case in the section on cancer of the uterine cervix. This 30 page chapter devotes a single, rather indifferent, page to the surgical treatment of this disease. While the majority of cervical cancers are suitable for radiotherapy, selected patients are better treated surgically. These are the early lesions and the not inconsiderable number of radiation-resistant and radiation-recurrent cervical cancers. The avowed purpose of this new book to bring essential information to practicing physicians is therefore, not consistently upheld when one recognizes that the family physician is the key figure in the diagnosis of uterine cancer. Obviously, he is often the most important advisor for the patient in the choice of treatment.

The chapter entitled "The Radiologic Diagnosis of Cancer" presents a grossly overenthusiastic account of the usefullness of lymphangiography. The dissertation on chemotherapy by Gordon Zubrod is exceptionally well written. The role of drug therapy in complementing cancer surgery and x-irradiation is properly emphasized.

In Part II, "Specific Considerations", the material is presented by well known clinicians who are recognized authorities on the subjects about which they write. The occasional devotion of long paragraphs to the egocentric description of some individual's "momentous contribution" (simple suction drainage of mastectomy wounds) can be overlooked in the wealth of more conservatively presented material.

This book is recommended as a suitable reference for those undertaking the management of cancer.

FITZHUGH MULLINS, M.D.



this part for diarrhea

Kaolin exerts a demulcent action along the gastrointestinal tract and a detoxifying action in the intestines to diminish irritation of the mucosa and lessen hyperperistalsis, nausea and diarrhea.

Pectin exerts its demulcent effect in the entire tract and its detoxifying action primarily in the large bowel to diminish irritation of the mucosa and help restore normal intestinal flora and function.

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References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., *32*:1227, 1948. 2. Hock, C.W.: Clin. Med., *8*:1932, 1961. 3. Winfield, I.W.: Am. J. Gastroent., *31*:438, 1959.

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in each 5 cc. teaspoonful:

Glyceryl guaiacolate	100 mg.

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new, non-narcotic
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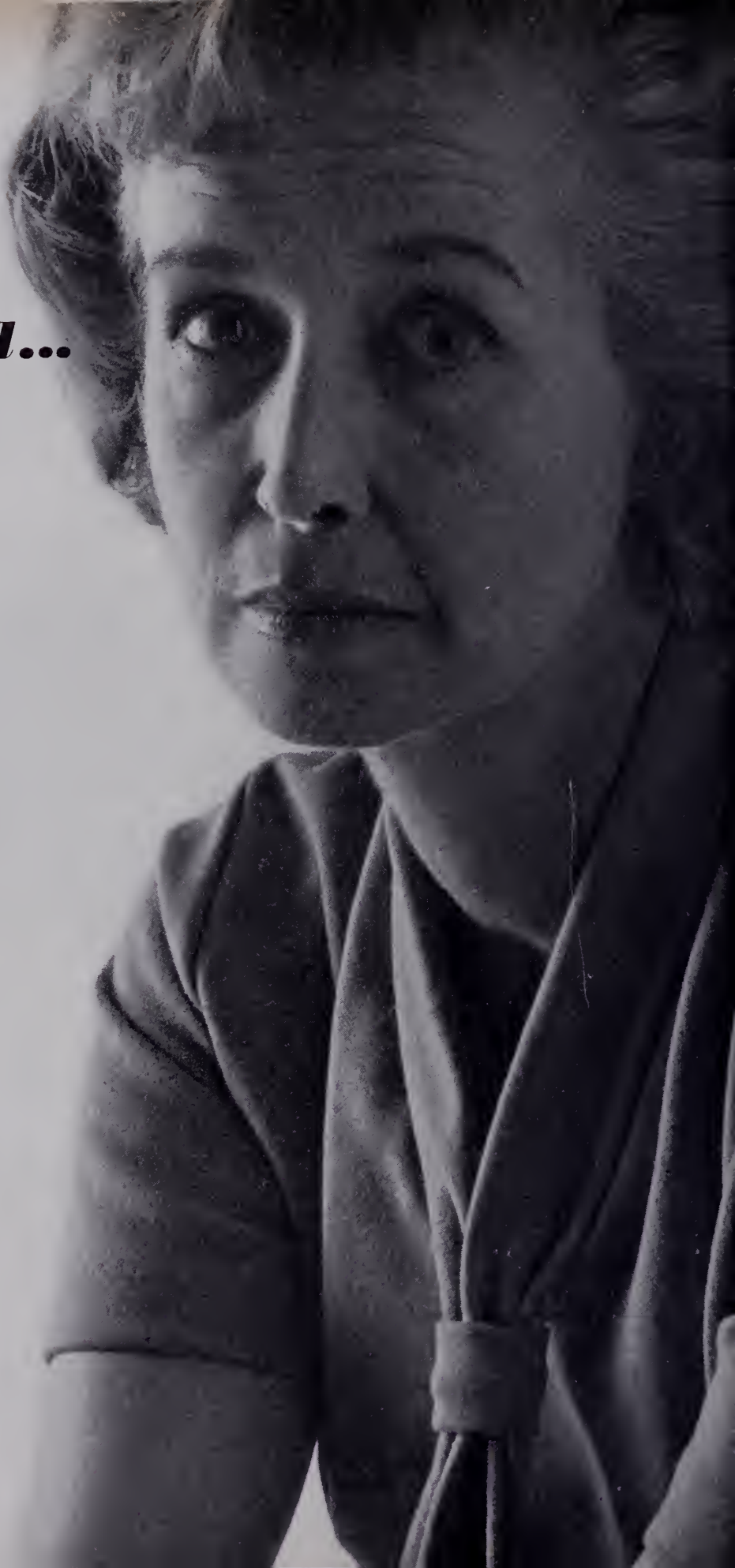
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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #18-64. A 37 year old married white gravida 3, para 1, whose expected date of confinement was August 13, 1964, was admitted on September 1, 1964 for elective induction of labor because of suspected postmaturity and a large baby. The patient's first child weighed 9 pounds. The prenatal course had been uneventful.

On admission, the fetus lay in cephalic presentation and the heart rate was counted at 144. The membranes were intact. The patient was given an enema, castor oil and one minim of Pitocin every hour for three injections. She began to have some irregular contractions after this, and at 5:30 P.M. on the day of admission, the membranes were artificially ruptured. The quality of the contractions improved after this, and the patient was given an unspecified sedative at 9:00 P.M. and 11:00 P.M. At the same time, penicillin was ordered to be given in doses of 600,000 units every 6 hours. At 11:30 P.M., the cervix was 6 centimeters dilated. At 11:45 P.M. she was taken to the delivery room, but was returned to her room as undeliverable.

On September 2, 1964, an x-ray showed an unengaged head and a very large baby. At 4:40 A.M., the cervix was thought to be 7 centimeters dilated; the fetal heart beat was counted at 140 in the right lower quadrant. She was catheterized but no urine was obtained. At 10:30 A.M., the cervix was completely dilated and the patient was again taken to the delivery room. A saddle block was administered, and her attending physician attempted a forceps delivery. When a good application of the forceps could not be obtained, an obstetrical consultant was called. The consultant found an obese woman in the lithotony position still under the saddle block, with a fetal heart beat of 140 in the right lower quadrant.

A vaginal examination showed the presenting part to be in the mid-pelvis. There was a large caput and much molding of the head. The cervix was completely dilated. Behind the posterior lip there was a bleeding transverse laceration 4 centimeters long in the posterior vaginal fornix. Kielland forceps were successfully applied but since there was no descent with reasonable traction, the consultant recommended delivery by cesarean section because of failed forceps. The patient was taken to the operating room where a living infant weighing 10 pounds 6½ ounces was delivered through a low cervical transverse incision at 11:52 A.M. under saddle block supplemented by general anesthesia. The patient tolerated the procedure well. Following the operation she was placed in lithotomy position for repair of the posterolateral vaginal laceration. An intravenous injection of 1 million units of aqueous penicillin was administered.

On the first postoperative day the patient was turning and coughing, there was no bleeding, the abdomen was soft, and the patient seemed to be doing well. On the second postoperative day bowel sounds were present and there was mild distention. The patient was allowed to sit up in a chair, the Foley catheter was removed, and an enema was given with "fair" results. On September 5, 1964, the third postoperative day, the patient complained of nausea and received 50 mg of Thorazine intramuscularly and 2 cc of Torecan. However, the distention continued to be marked so a Levin tube was inserted and continuous suction was started. One liter of Dextrose in water was given intravenously. Approximately 2000 cc of fluid was removed by suction on September 6. The suction was continued and the patient received 1000 cc of normal saline with 40 meq of potassium chloride and 1000 cc of Dextrose in water. Bowel sounds were present on September 7, and the abdomen was flat and soft. For the first time during this hospitalization she exhibited fever (100.2°). The patient was also passing gas rectally so the Levin tube was removed and a small enema was given with fair results. She was able to walk to the bathroom, where she had a spontaneous bowel movement at 11:00 A.M. At this time the patient complained of chest pain, but her blood pressure and pulse were stable and there was no cyanosis. At 3:00 A.M. the patient, who was lying on her side, called for the nurse. The nurse responded immediately and found the patient vomiting, cold, clammy, moaning, gasping, and cyanotic. The pulse was weak and thready. An attempt was made at mouth to mouth resuscitation and positive oxygen, but the patient stopped breathing at 3:15 A.M. No autopsy was performed.

The final recorded diagnoses were intrauterine pregnancy delivered at term with cephalopelvic disproportion; amnionitis; pelvic cellulitis, diffuse peritonitis, pelvic abscess, adynamic ileus, and probable pulmonary infarction.

Comments

The Committee considered this a direct obstetrical death with preventable factors on the part of the attending physician. The recognition of cephalopelvic physician to seek consultation before attempting what promised to be a difficult forceps delivery. disproportion should have prompted the attending The terminal event may have been a pulmonary embolus, and does not seem to have been preventable.



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Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et ol.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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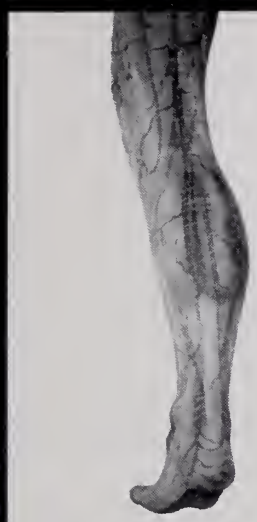
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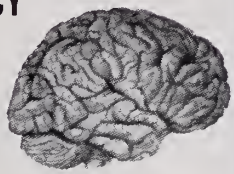
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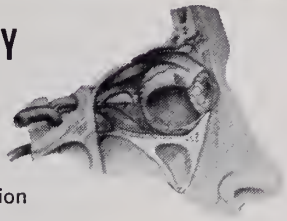
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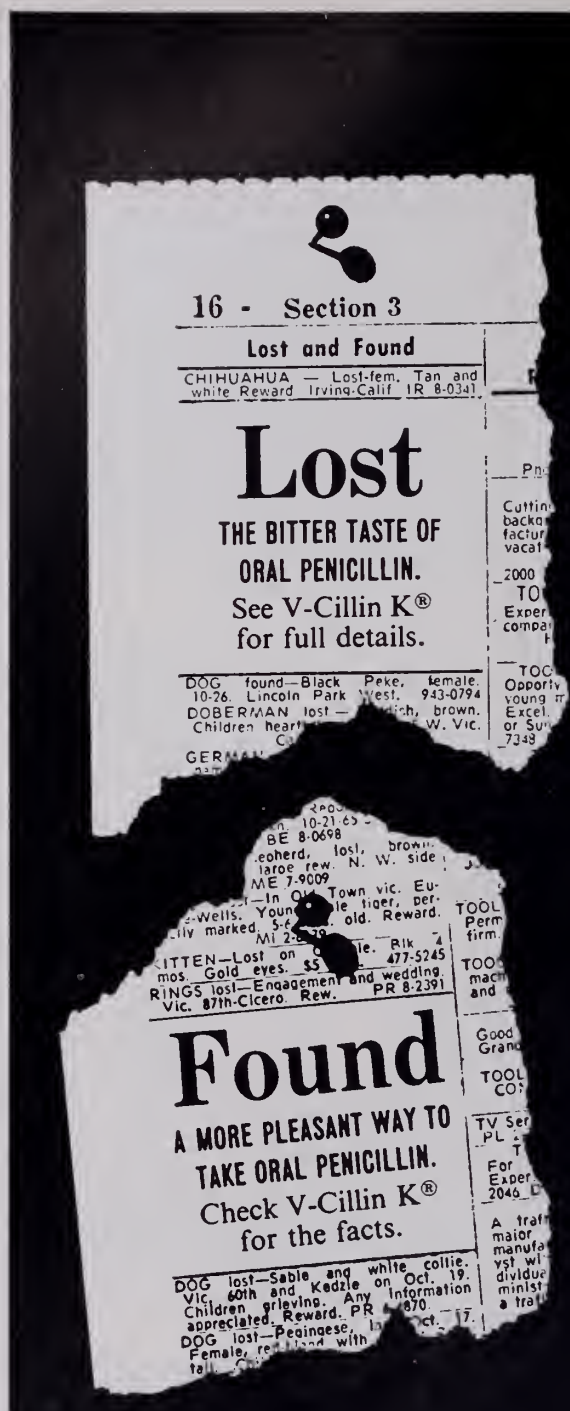


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VOLUME 64 FEBRUARY, 1966 No. II

Your Psychiatric Patient at Work†

ALAN A. MCLEAN, M.D.*

Armonk, N.Y.

Time off from the job is examined as a means of treating the psychiatric patient. The author explores work situations as the basis for many emotional problems.

TODAY OUR concept of what constitutes work is quite different from what it has been in the past and from what it will be in the future. In broad historical perspective, our present concept is a transitory one. In times past, life was much more of a totality. It was not split into what a man does to earn a living and what he does during the rest of the time. In many cases there was not even a word for work. Our own ideas today of the nature of work as a special area in our total social activity did not apply. In more primitive life, we would be forced to speak of work as something as broad and indefinite as the very incentive to live.

So far as the future is concerned, we are offered the image of a wholly mechanized and automated society where the problems of leisure time weigh heavily on the shoulders of a prosperous single class of citizens who will "work" but, perhaps, ten hours a week.

Today work remains central in the lives of most of our patients. For forty hours and more each week their thoughts and feelings and identifications are work centered. Few Americans find it easy to be happy unless they are doing something. We live in a land of haste, bustle, and strenuous competition where the individual is interested in making things happen to the external world—where he seeks to dominate the world of nature, to subdue and exploit the physical world around him. Activity is considered a national characteristic and with our cultural heritage of activity and hard work, we find that even with a reducing hourly work week a job continues to play a dominate role in our lives and our identifications are increasingly with a large corporate employer—his values grafted on to our own. It is no happenstance that these corporate values and interests increasingly dominate a society in which mobility and rootlessness cause an intensification of the bonds which tie an employee to the values of the employer. It is no surprise that we no longer introduce ourselves as John Smith, but rather as John Smith of the Ajax Manufacturing Company. It is no surprise that two strangers discovering they work for the XYZ Corporation will find much in common.

Most recent studies suggest that something over 30 per cent of the typical industrial population would present symptoms of emotional difficulty at any given time. Such reactions range from a typical, mild psychosomatic headache to incapacitating psychotic reaction. The same researchers suggest about 10 per cent of an industrial population is incapacitated from productive work to some extent as a result

†*Presented at the September 22 General Session of the Kentucky Medical Association Annual Meeting in Louisville, September 21-23, 1965.*

**Psychiatric Consultant, International Business Machines, Armonk, N.Y.*

of the same disturbances. Most large companies would agree that about 2 per cent of the work force require either a change in job or a significant loss of time from work in a given year because of major emotional difficulties.

Work has an increased psychological and social meaning, and workers have an apparently greater incidence of psychiatric disorder. What is the role of the physician who serves this working population?

To explore several aspects of the physician's role, I would like to focus on three topics. First, is the common prescription of time off from work in treatment of psychiatric disorder. Second, is the role of personally stressful factors such as physical illness in sensitizing an employee to unhealthy reactions to changes in his work situation. Third, I think it would be useful to demonstrate the value of appropriate medical care for the employee with a psychiatric problem.

Time Off for Psychiatric Illness

The medical consultant to industry has many ways to assist the individual and the organization in cases of emotional disturbance. He is concerned with proper job placement, for instance—the assignment and reassignment to positions which appropriately use the employee's skills and abilities and do not adversely influence his health. A work assignment which considers the current psychological needs of the employee most certainly pays off for everyone involved. A great many seriously ill individuals can function effectively on the job if that job is realistically matched to his abilities. I can think of several individuals with chronic psychotic illness, patients who have hallucinations and delusions but who are well able to function in capacities ranging from washing glassware in a laboratory to highly technical research assignments. The physician is a vital industrial resource in this placement activity.

For an employee who develops an emotional illness, there are many traditional techniques for managing the problem. A variety of well-intentioned and fundamentally sound human relations policies and industrial medical practices are frequently employed.

Most companies have policies covering sickness absence from work with pay. The initiation of such an absence may come from the employee's physician, from his foreman, from the company medical department, or from the worker himself. Sometimes an employee who appears worried, anxious or depressed is told to take a few days off to "snap out of it."

There is the common belief that rest is health promoting, so it is understandable that the suggestion of rest should be made in the case of an individual reacting to psychological stress. Change in the external environment, however, is not always stress reducing. The troubled employee may go on vacation, taking his worries with him, and hence feel no better than when he is at work. We may lose sight of the fact that work in and of itself is often a health promoting activity. The acceptance of responsibility may be the main healthy component in an employee's life. The job often provides him with a feeling of worth and a sense of accomplishment, both of which contribute to his mental health. Conversely, telling the employee that he is not able to work makes him feel that he *must* be sick and so becomes a second source of anxiety and depression.

Does the employee-patient who is depressed interpret the suggestion of a few weeks off "to get over it" in the same way as his management or his physician? He may comment that he does not *want* such considerate treatment. This may be recognized by the astute observer as arising from his feelings of unworthiness—a symptom of his depression.

Is the depressed person not more apt to interpret an instruction to leave the job for a few weeks as rejection on the part of the physician and on the part of the company? Might he not take this as outside proof of the accuracy of his own feelings about himself? Would this not tend to confirm his opinion that he is, indeed, worthless and useless? Time at home to brood over his ideas about himself does not usually seem the wisest solution to the problem. Might not a better solution be found in the more careful investigation of the situation and referral to a competent physician for evaluation and treatment?

Removing an employee from active work may also create problems of dependence. When taken off the job, he is placed in a dependent position. Symbolically he is no longer a productive wage earner. This, in turn, may tend to increase the feelings of helplessness and dependence upon others which were *already*

a part of his disability. While time off may, for the moment, alleviate some of his problems, it will in the long run often add further problems and make more difficult his adjustment to the job on return.

Some of the same ideas apply also in the case of the shy, withdrawn individual. For some seriously suspicious and moody people, the suggestion that he leave his job can be disastrous. Far better than insisting on time off the job for such an individual with his delusional systems, is that he be referred to a competent physician and at times on to a psychiatrist who may at this stage begin treatment to prevent further development of such an illness and to help re-establish the person's usual pattern of behavior.

And for the individual with an anxiety reaction whose tensions build up to the point that his productivity falls off and his social adjustment becomes difficult, surely a month or two at home to dwell upon his inadequacy is not the best therapy, even with weekly visits to his physician.

In this case the private practitioner may again play a role in the prescription of sick leaves. At times the only solution to such an emotional problem that the hard pressed doctor can arrive at is that of time off, often at the insistence of their patient.

There are many occasions when a change of pace and a change of scene do play a valuable role in treatment. Probably the majority of recommended sick leaves are medically and psychologically advisable. It is only the occasional episode, admittedly, which calls attention to the psychiatrically unsound prescription of such time off. Both industrial physicians and personnel people are becoming more experienced with, and more aware of the dangers inherent in the use of this seemingly liberal human relations practice.

"My Job Makes Me Sick"

We often hear from our patients that pressures at work are stressful, that changes in the job have triggered feelings of depression, anxiety and more severe forms of emotional reaction. And certainly there are situations in the work environment which can be acutely stressful and which can lead to the development of incapacitating symptoms—the assignment of a new boss, the assignment to a position which calls for the development of new skills, the unexpected need to meet deadlines, conflict between a worker's goals and aspirations and the pressures from the work group.

In particular, it has been said that symptoms of mental illness arise from a change in relationship between an employee and an employer. Changes have included promotions, demotions and lateral transfers, and alterations in production schedules.

A colleague and I studied a group of 27 such cases—patients who were incapacitated by psychiatric illness *and* who reported a change in relationship with their employer immediately prior to the onset of symptoms.*

Psychiatric diagnoses reported were most frequently depressive reactions although there were also psychoneurotic illnesses and a scattering of other reactions. Interestingly enough, each of these patients, all men, had symptoms which developed during middle life; the average age was in the early fifties. No previous episodes of emotional illness were reported. Each had been with his employer more than 25 years. Seven different companies were represented and occupations ranged from skilled craftsmen to corporate officers.

Many occupational changes *appeared* to trigger the emotional reactions. They ranged from retirement without anticipated pre-retirement promotion to promotion itself. Changes in supervision and assignment to jobs which displaced the skills of the individual involved with automated equipment were also noted.

The primary finding from a study of this group of patients was that while the emotional reactions occurred in a setting of occupational change, they developed invariably at a time the individual was adjusting to an unrelated personal stress or physical illness. The length of time between these associated extrinsic factors and the time of development of symptoms of psychiatric illness ranged from three to six months. Apparently, for this group of older employees, when external influences had strained the patient's ability to adapt, he turned for emotional support to his close relationship with his company.

Every one of these men had either suffered an acute physical illness or experienced a severe personal stress which immediately pre-

*"*Medical Problems in Employment Continuity of Senior Citizens," New York State Journal of Medicine, Vol. 61, No. 17, Sept. 1, 1961.*

dated the development of symptoms of psychiatric illness. The illnesses included cardiac decompensation, iritis, osteroarthritis, and acute cholecystitis. Personal problems included a serious illness of a spouse, acute personal financial reverse, and the loss of a love object such as a son, a parent, or a home.

I may very briefly summarize our findings by saying that there appeared to be a common chain of events of an initial dependency relationship with a company which had existed for many years, a stressful external problem situation to which the individual apparently adapted fairly well and without symptoms, followed by a major alteration in the work environment with a disruption of the dependency relationship which led to a serious emotional reaction requiring absence from work and psychiatric treatment.

Many questions may be raised by such findings. Perhaps the most important for us today is the need for sensitivity by physicians who serve as industrial consultants as well as by industrial management—sensitivity to factors in the worker's life outside the job. The role of the employee's physician is to bring these external stresses to the attention of his employer at the time of any anticipated job change.

One Plant's Experience

In one rather typical manufacturing location employing about 3,500 people, 71 employees had emotional problems of such a nature as to interfere with interpersonal relationships and work performance over a period of time greater than one year or had repeated shorter periods of psychiatric disturbance of such intensity to interfere with their work. An interested and competent internist serving this location studied this group quite carefully. Initially, he determined whether they were presently "compensated" or "uncompensated." By compensated he meant that they were presently performing satisfactorily and had not been absent for more than 7 days (the plant average) in the past 12 months because of reasons directly referable to the emotional problem. By uncompensated he meant those who had missed 14 or more days from work in the past year because of emotional difficulty *and* had required a change in work assignment. Many hours of management, personnel and medical department time had been spent in trying to help these uncompensated people reach a satisfactory adaptation to their work. He discovered that 22 individuals could be called compensated and 49 uncompensated at the time of the start of the study.

Uncompensated cases had illnesses of much longer duration. Most had brought their emotional problems with them when they came to work.

The effect, or lack of it, of medical treatment in this group of 71 patients was carefully evaluated. For purposes of estimating the effectiveness of treatment it was desirable to subdivide the uncompensated cases into those who continued to be uncompensated and those who had been uncompensated at the start of the study 12 months ago but were now under treatment and working at a satisfactory level.

The type of treatment given people in this study was differentiated into two major categories: good supportive treatment most often including psychotherapy, and, drug therapy alone. Those people considered to be receiving good supportive treatment visited their psychiatrist or other physician on a reasonably regular basis and felt that someone understood their problem. They may also have been receiving medication. Drug therapy alone, however, means that while their illnesses had no organic basis, they were told that their problem was "nerves" and received a prescription for "the tranquilizer of the week" without much further direction. The results are most interesting. Of the presently uncompensated cases, 4 were receiving good supportive therapy and 23 drug therapy alone. Of the previously uncompensated cases who are now working well, 21 were receiving good supportive therapy and 2 drug therapy alone. Of those cases who were completely compensated, 18 were or had been receiving good supportive therapy and 3 drug therapy alone.

This study suggests why industry and industrial medicine are increasingly concerned with employees obtaining appropriate medical treatment for psychiatric disorders. It further suggests the overwhelming majority of disrupting emotional disturbances perceived in industry are amenable to treatment.

(Continued on Page 168)

Amniotic Fluid Analysis in Rh Sensitized Pregnancies

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Lexington, Ky.

A simple, precise method is now available to assess the status of the fetus in these complicated pregnancies.

IN 1961, Liley[1] reported that the spectrophotometric analysis of amniotic fluid from Rh sensitized pregnancies could give an accurate and objective index of the status of the fetus in Rh sensitized pregnancies. His investigations had been based on the previous work by Bevis[2] and Walker[3] who had demonstrated that in such pregnancies with an affected fetus a specific yellow pigment appeared in the amniotic fluid. The concentration of this pigment was inversely proportional to the hemoglobin of the baby. Thus, the greater concentration of this pigment, the more anemic was the baby. For the first time a method was reported to assess the status of the fetus in these complicated pregnancies independent of the antibody titers in the maternal serum. It has been recognized that antibody titers are often an unreliable diagnostic index. That is, in cases with very high antibody titers, one can see an Rh negative baby and with very low antibody titers stillbirth does occur. This new technique created considerable enthusiasm in many centers around the world.

For the past two years, spectrophotometric analysis of amniotic fluid from Rh sensitized pregnancies has been routinely done at the University of Kentucky Medical Center. It has been confirmed that this is a reliable and sensitive test of the status of the baby in these pregnancies. The test is simple. The initial amniotic fluid sample is obtained by transabdominal amniocentesis at 26 to 32 weeks gestation, depending on the previous obstetric and immunologic history of the patient. The fluid is centrifuged free of cellular debris and analyzed for optical density across the visible spectrum of light. If the fetus is unaffected or Rh negative, there is a relative straight line in the visual spectrum as shown in Figure 1. In affected pregnancies, a pigment appears and absorbs light at 450 millimicrons as shown in Figure 2. The height of this peak of optical density at 450 millimicrons is directly proportional to the severity of the infant's affliction. Liley has presently prognostic charts so that one can immediately make a statistical prediction of the degree of affection of the given infant.[1, 4]

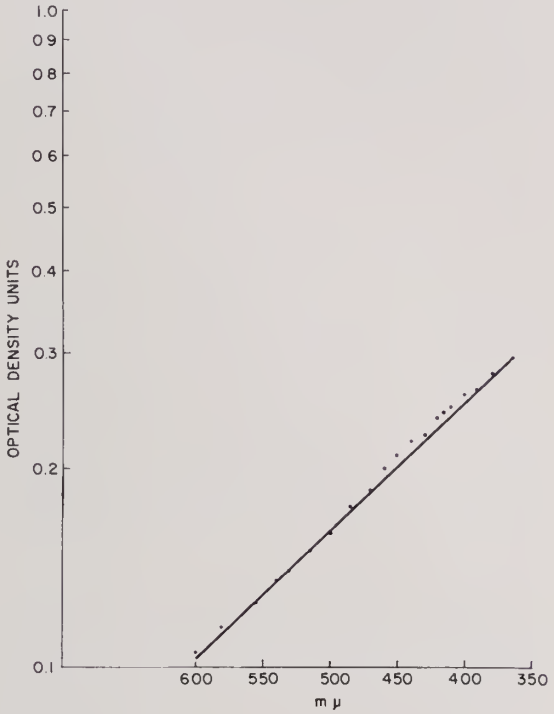


FIGURE 1. Results of spectrophotometric analysis of normal amniotic fluid. Notable is the relatively straight line from 555 millimicrons to 360 millimicrons when optical density is plotted on a logarithmic scale.

In the management of a pregnancy complicated by Rh sensitization, usually three analyses of amniotic fluid are performed at progressive weeks of gestation. If these indicate the fetus is not severely affected, the pregnancy may be allowed to terminate in

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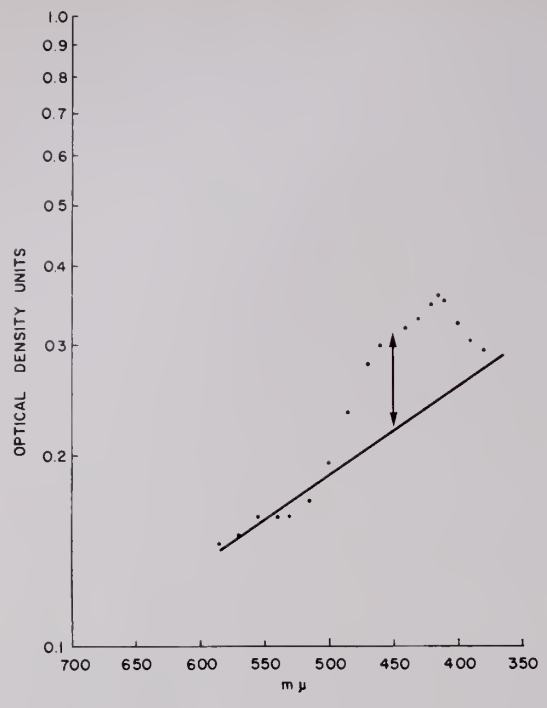


FIGURE 2. Results of spectrophotometric analysis of amniotic fluid from an affected pregnancy. The normal straight line is constructed from 555 to 360 millimicrons and the height in optical density units at 450 measured.

spontaneous labor at term. If, on the other hand, fluid analysis indicates that the infant is becoming anemic in utero, earlier termination of the pregnancy is indicated and may be rather precisely timed. The decision rests on the risk of further in utero existence compared with the risk of premature delivery. Two cases will be presented which are indicative of how this test has been of great help in managing these frequently perplexing patients.

Case Reports

Case No. 1. B.L. (01-63-36), a 25 year old Gravida V, Para IV, had a living child from her first pregnancy only. The subsequent three pregnancies had terminated in a hydropic stillborn at seven to eight months' gestation due to erythroblastosis. The patient's LMP was March 22, 1963, giving her an expected date of confinement of December 29, 1963. The patient's blood type was determined to be O cde/c. Her husband was also typed and found to be cDe. The patient was first seen at the University of Kentucky Medical Center on October 15, 1963, with an antibody titer of 1:1024. At this time an amniocentesis was done and the fluid subjected to analysis. Subsequent fluid analyses were made and all of these were within the lowest range despite the fact that her antibody titer rose to 1:2048. These results are shown as the solid line in Figure 3. At 40 weeks gestation, an elective induction of labor was done, resulting in the delivery of a 2940 gram living female infant whose blood type was O cde/e. The baby and her mother did well in the postpartum period and were discharged from the hospital on the fifth postpartum day in good health.

This case illustrates how amniotic fluid analysis can be used to carry a pregnancy to greater maturity despite immunologic indications of impending fetal disaster. When the patient was first seen, it was felt that this was a desperate situation, due to her past history and present antibody titer. However, serial fluid analyses indicated that the baby was not affected and, accordingly, the pregnancy was allowed to continue to 40 weeks gestation. It is likely that without the guidance of the amniotic fluid analysis, this pregnancy would have been terminated on empirical grounds as early as 34 weeks with the risk of neonatal death due to prematurity.

Case No. 2. M.H. (X2-17-65) was a 29 year old Gravida III, Para II, whose first two pregnancies were uneventful with no evidence of Rh sensitization. During the present pregnancy, a routine antibody titer was obtained at 20 and 32 weeks gestation. Initially, there was no antibody titer but at 32 weeks a low titer was found. Accordingly, amniocentesis was performed at 33, 35 and 37 weeks as shown as the broken line in Figure 3. The

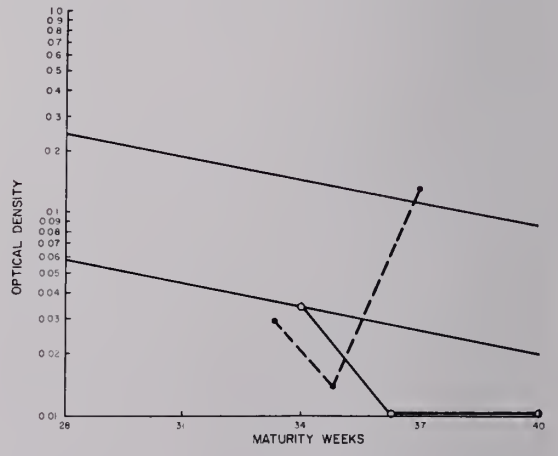


FIGURE 3. Optical density at 450 millimicrons above the constructed base line in two Rh sensitized pregnancies. The diagonal lines delineate low, moderate, and high risk zones (modified from Liley). The solid line represents Case 1 and the broken line represents Case 2 in the text.

specimen at 37 weeks showed a marked rise in optical density at 450 millimicrons and, accordingly, she was delivered that night. At delivery, the infant had a cord hemoglobin of 10.0 with a 4 plus Coombs reaction and required exchange transfusions.

In this instance, based on past history and antibody titers, the fetal risk in this pregnancy would have been considered minimal and it is likely that the pregnancy would have been carried to term. However, this baby was anemic at 37 weeks and may well have been hydropic if allowed to remain in utero for another three weeks.

Discussion

Since the development of this technique, it is advisable to evaluate the progress of every Rh sensitized pregnancy by means of amniotic fluid analysis. Serial antibody titers are no longer routinely performed or utilized to direct management. Every patient is initially screened for Rh antibodies, and if present, the patient is a candidate for serial fluid analyses. This is an accurate and sensitive index of the status of the fetus. The two cases presented illustrate how the information obtained from the amniotic fluid can direct a course of management that may well be diametrically opposed to the course pursued if only past history and immunologic data are considered. In the hands of experienced personnel, the aspiration of amniotic fluid is a safe procedure for both the mother and the baby. The laboratory procedures involved are relatively simple and inexpensive.

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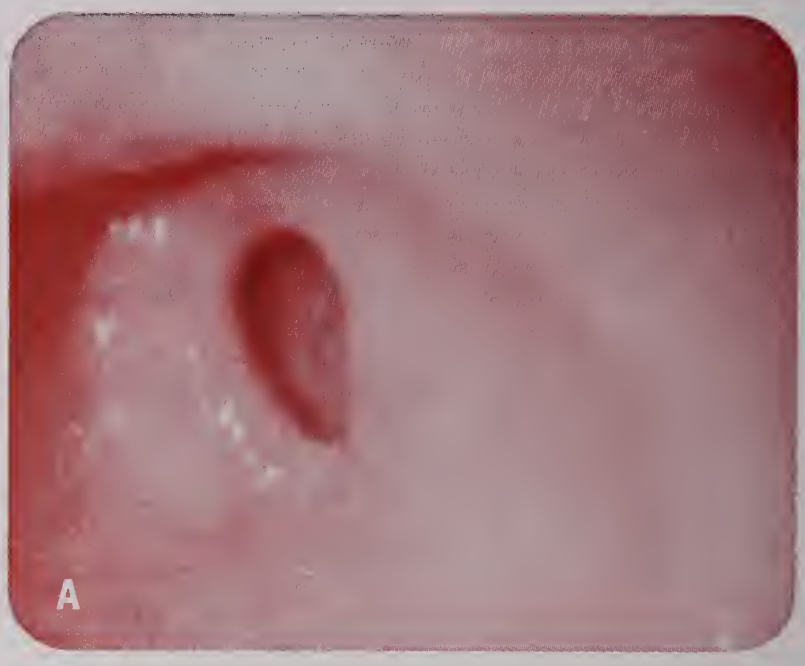
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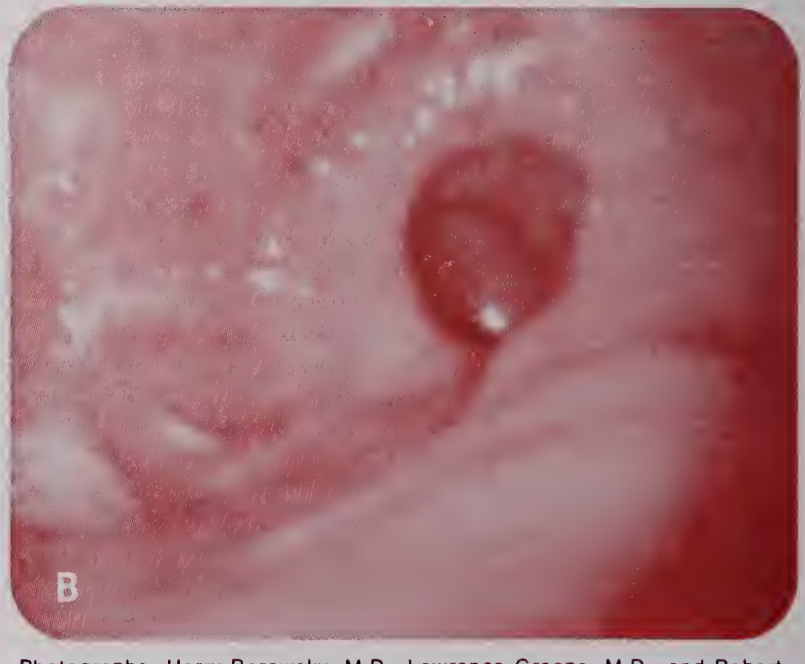
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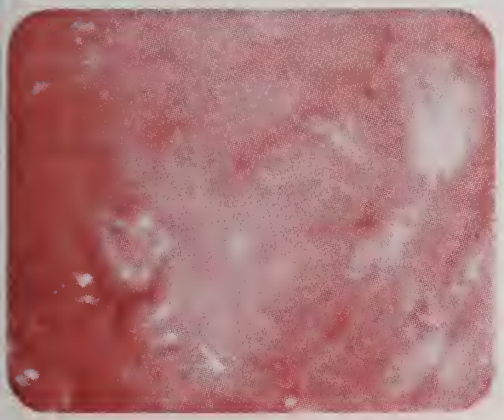


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Photographs—Harry Barowsky, M.D., Lawrence Greene, M.D., and Robert Bennett, M.D., from a Scientific Exhibit presented at the Annual Meeting of the American College of Gastroenterology, Bar Harbour, Florida, Oct. 24-27, 1965.

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SEARLE

Research in the Service of Medicine

Surgery of the Rheumatoid Hand

Paul M. Weeks, M.D.*

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A description of the pathologic and subsequent dynamic changes occurring in the rheumatoid hand is presented. Prophylactic and therapeutic surgical interruption of these progressive changes is described.

DISABLING deformities of the hands are present in 25 to 30 per cent of the patients with rheumatoid arthritis. In recent years surgical techniques have been developed for prevention and/or correction of these deformities. The purpose of this review is to describe the pathologic and subsequent dynamic changes occurring in the hand as a result of the rheumatoid process and to outline the surgical procedures available for prevention or correction, as indicated, of these deformities.

Pathological Changes

The fundamental manifestations of rheumatoid arthritis in the hand are: 1, an inflammatory proliferation of the synovium surrounding tendons, tendon sheaths, and lining joints, and 2, inflammation and spasm with subsequent atrophy and contracture of the intrinsic muscles.

Proliferation and inflammation of the synovium lining the joints is manifest clinically, as swelling, redness and pain. A low grade fever may be present. The proliferating synovium, which has the appearance of granulation tissue, invades the head of the metacarpal at its junction with the articular cartilage. Similar invasion, but to a lesser degree, occurs at the base of the proximal phalanx. Progressive proliferation and invasion by the synovium eventually destroys the articular surface and the bony metacarpal head. The articular surface of the proximal phalanx is preserved, in part, although the entire metacarpal head may be destroyed.

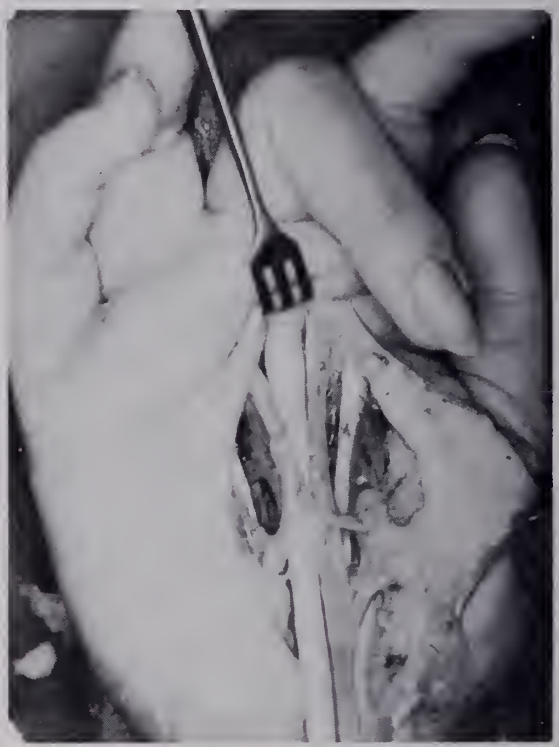


FIGURE 1. Note the bulbous enlargement of the long finger flexor tendons proximal to the stenotic digital sheath opening. At the wrist, compressive and hemorrhagic changes are present in the median nerve.

The insertions of the collateral ligaments into the metacarpal head become tenuous as the head is resorbed. The bony attachments of the volar plate are similarly attenuated permitting hyperextension of the joint. Loss of the stabilizing influence of the collateral ligaments and volar plate subjects the phalanges to the overwhelming forces of the ulna oriented long flexor and extensor muscles.

The flexor and extensor tendons are encompassed by synovium in specialized areas. The synovium encompassing the extensor tendons is limited to the dorsal retinaculum at the wrist. On the flexor surfaces of the hand and forearm, the synovium lines the digital tendon sheaths and extends proximally along the flexor tendons through the palm and into the forearm as a loose film of tissue.

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FIGURE 2. The boutonniere deformity is the result of detachment of the central tendinous slip from the middle phalanx and displacement of the lateral bands volar to the axis of rotation of the proximal interphalangeal joint.



FIGURE 3. The characteristic swan-neck deformity with hyperextension of the proximal and flexion of the distal interphalangeal joints.

An inflammatory proliferation of the lining of the digital sheath can produce a stenosing tenosynovitis and result in a "snapping finger". Spontaneous rupture of the flexor or extensor tendons is attributed to compromise of the blood supply and actual invasion of the tendon by the proliferating synovium. Compression of the median nerve in the carpal tunnel by the proliferating mass is not uncommon (Figure 1).

The inflammatory and degenerative changes in the extrinsic and intrinsic muscles of the hand have been described by Kestler (1949). They are: 1, infiltration of the muscle by lymphocytes, plasma cells and epithelioid cells; 2, degeneration of the muscle cells as evidenced by enlargement and vacuolization of the nuclei, with progressive fatty infiltration and muscular atrophy; 3, perivascular round cell infiltration and thickening of the vessel walls with impingement on the lumen; and 4, fibrinoid changes in the connective tissues and sclerosis of the collagenous fibers. The early inflammatory changes are accompanied by muscular spasm and later result in atrophy and fibrosis with contracture of the involved muscles.

The Dynamics of Rheumatoid Deformities

The deformities, to be described, result from a combination of unstable joints and spastic muscles. These include: 1, the swan-neck deformity, 2, the boutonniere deformity, 3, ulnar drift of the fingers and, 4, subluxation of the metacarpal phalangeal joints. The developmental dynamics of each deformity will be described.

The boutonniere deformity (Figure 2) is the consequence of synovial disease at the proximal interphalangeal joint with disruption of the insertion of the central slip of the extensor tendon. This accompanied by attenuation of the overlying dorsal hood allows the proximal interphalangeal joint to herniate between the lateral bands. The lateral bands are then volar to the axis of rotation of the joint and become flexors rather than extensors of the joint. Spasm of the intrinsic muscles exaggerates and maintains the deformity.

The swan-neck deformity (Figure 3) is attributable to either spasm of the extensor muscle which inserts into the base of the middle phalanx or spasm of the intrinsic muscles. Attenuation of the volar plate attachments by joint disease permits hyperextension of the proximal interphalangeal joint which is maintained by the spastic muscles. Flexion at the distal phalanx results from the overpowering pull of the long flexor tendons. To detect spasm and shortening of the intrinsic muscles, the metacarpal phalangeal joint is hyperextended. In this position attempted flexion of the distal phalanx encounters unyielding resistance. Tautness of an extensor muscle is similarly detected but with the metacarpal phalangeal joint in marked flexion. Not uncommonly both contribute to the deformity by amalgamation of the extensor tendon and the lateral bands over the inflamed proximal interphalangeal joint.

Subluxation of the metacarpal phalangeal joints (Figure 4) is the product of an imbalance of the extrinsic and intrinsic muscle pull combined with varying degrees of joint disease as described earlier. With unstable joints, the extensor tendons are displaced into the grooves between the metacarpal heads thus increasing ulnar deviation of the fingers. Spasm of abductor digiti quinti muscle can contribute markedly to the ulnar drift of the digits by constant pull on the attached volar plates and



FIGURE 4. Note displacement of the extensor tendons between the metacarpal grooves. Subluxation and marked ulnar drift of the digits.



FIGURE 5. The dorsal hood has been retracted and the thickened synovium of the metacarpal phalangeal joint excised. Note the destruction of the metacarpal head where the synovium has invaded.

associated proximal phalanges of the digits. The first dorsal interosseous is frequently found displaced beneath the index metacarpal, suggesting displacement by ulnar shift of the volar plates. In addition, the powerful long digital flexors contribute to subluxation of the metacarpal phalangeal joints.

Prophylactic Surgery

The selection of patients for surgery is most important. To obtain the greatest benefit from surgery they must be well motivated and mentally attuned to the rheumatologist, the surgeon, and the physical therapist. Adequate forearm musculature is mandatory. Such patients can be operated upon during periods of exacerbation or remission of the disease without fear of further activating the disease (Vainio, 1959).

Preventive or prophylactic surgery involves removal of the proliferating synovium at the dorsum of the wrist; in the flexor tendon compartments; and within the joints as indicated.

Extensor tendon synovectomy—The dorsal retinaculum of the wrist is exposed through an S-shaped incision. The retinaculum is incised laterally and opened throughout its transverse course to expose each compartment with its contained tendon(s). With the retinaculum reflected, the synovium encompassing the extensor tendons is excised. The flap of dorsal retinaculum is replaced beneath the extensor tendons. If the disease has extended between the carpal bones or if the distal end of the ulna is subluxated, the synovium is removed and the protruding ulna excised.

Flexor tendon synovectomy (Figure 5)—In the presence of tenosynovitis of the flexor compartment, excision of the synovium is performed to prevent rupture of the tendons or limitation of motion by adherence between the tendons. When the process extends into the palm it is removed at the same sitting. Occasionally there is marked limitation of flexion in the digits and loss of strength as a result of adhesions between the sublimus and profundus tendons. This may necessitate removal of the sublimus tendons to restore function.

Joint synovectomy (Figure 6)—The metacarpal phalangeal joint frequently requires synovectomy, either prophylactically or during the correction of deformities. This is accomplished through a serpentine incision over the metacarpal heads. Skin flaps are developed and care taken to preserve the large dorsal veins between the metacarpal heads. A transverse incision on the radial side of the hood exposes the joint capsule. The synovectomy



FIGURE 6. The flexor tendons are encased by the proliferating synovium which eventually invades the tendons and leads to its spontaneous rupture.

begins at the head of the metacarpal and is completed by detaching it from the base of the proximal phalanx. In prophylactic excision the collateral ligaments are preserved. A curette is used to remove the synovium lining the collateral ligaments and in the deep recesses of the joint. The hood is then overlapped on its radial side and repaired with mattress sutures. In this manner, the extensor tendons are repositioned atop the metacarpal phalangeal joints. The wound is closed and a compressive dressing applied. Passive, then active exercises are begun when the wound has healed.

Reconstructive Surgery

For correction of disabling deformities synovectomy combined with resection of the partially destroyed metacarpal heads and restoration of muscle balance is necessary.

Joint synovectomy and arthroplasty are indicated when there is ulnar drift and/or palmar subluxation of the phalanges associated with partial or total destruction of the metacarpal heads. The synovium is exposed and excised as outlined previously. Various methods of arthroplasty are available, all of which involve partial or total excision of the metacarpal head and excision of any exostosis of the proximal phalanx. Any articular cartilage on the base of the base of the proximal phalanx is preserved. The displaced extensor tendons are relocated by reefing of the radial side of the extensor hood. The Fowler technique of arthroplasty has proven very satisfactory. This includes bevelling the remaining portion of the metacarpal head in a lateral and dorsal plane to overcorrect for the ulnar drift.

Kirschner wires are inserted through the proximal phalanx and into the metacarpal to stabilize the joint in moderate flexion until the wounds have healed. The wires are removed in 12-14 days and passive and active motion begun.

Arthroplasty is limited almost entirely to the metacarpal phalangeal joint as surgery on the smaller joints frequently results in instability of these joints.

Occasionally we have noted fusion in the functional position of the resected metacarpal-phalangeal joint on which an arthroplasty was performed. These patients have complained that the fused metacarpal-phalangeal joint is not as useful as the ones with motion, however slight it may be. This suggests that, if it is possible to preserve motion and correct the deformity, arthroplasty should take precedence over joint fusion. Fusion of single joints, as in the thumb, has definite indications and is beneficial.

Joint prosthesis—In recent years the use of joint prosthesis has been intensely studied in this country by Flatt. He suggests that if the extensor tendon mechanism is intact, the indications for prosthetic replacement of the metacarpal phalangeal joints are: 1, gross destruction of the joints, and 2, palmar and proximal dislocation. He reports good functional results with prosthetic replacement of joints. A few have had to be removed for malfunction of the prosthesis, resorption of bone with migration of the device or infection.

Surgery is primarily directed at restoration of muscle balance in the following deformities: 1, swan-neck, 2, boutonniere and, 3, ulnar drift of the fingers.

The swan-neck deformity, with intrinsic contracture, can often be corrected by resection of a portion of the lateral bands of the extensor hood (Littler). If exaggerated pull of the extensor tendon is present this can be relieved surgically by elevation of the lateral band at the level of the proximal interphalangeal joint and careful detachment of the insertion of the central tendinous slip into the middle phalanx. Care is taken to preserve the triangular ligament. Both procedures can be performed on the same finger with good results in selected cases.

The boutonniere deformity is difficult to repair surgically. Repair has been suggested by reattachment of the central slip of the extensor tendon to the base of the middle phalanx utilizing a free tendon graft (Nichols). The graft is woven into the lateral bands and replaces them above the axis of rotation of the joint.

In early ulnar drift the surgical objectives are removal of the diseased synovium and relocation of the displaced extensor tendons. The former is accomplished by synovectomy through an incision on the radial side of the extensor hood as outlined earlier. Relocation of the extensor tendons is accomplished by reefing the extensor hood on its radial side and maintaining this with mattress sutures. Release of the hood by an incision on its ulnar side may be necessary to relocate the extensor tendons atop the joint. Tendon trans-

fers to the radial side of the hood have been advocated to prevent recurrence of the ulnar drift. Transfer of the extensor indicis proprius tendon to the radial side of the index finger and the extensor digiti quintis to the radial side of the fifth finger is of benefit.

In late cases of ulnar drift with subluxation of the metacarpal phalangeal joint, the surgical objectives are: 1, removal of the invasive synovium, 2, arthroplasty of the metacarpal phalangeal joints, and 3, relocation of the displaced extensor tendons.

The post-operative period is critical and it is important that the patient be followed closely by the hand surgeon, the rheumatologist, the physical therapist and the rehabilitation specialist. It is during this time that the patient's need for encouragement, instruction and understanding are greatest. In the case of a simple synovectomy, release of intrinsic contracture or detachment of the central tendinous slip, the dressings are removed on the fifth post-operative day and exercises begun. When excision of the metacarpal heads or tendon transfers are necessary the hand remains immobilized for two weeks. The Kirschner wires are removed and passive exercises begun. Active motion is instituted three weeks post-operatively. The use of dynamic splints at this time can be of great value in aiding exercises and preserving alignment of the digits.

Surgery of the rheumatoid hand is relatively new; however, certain basic principles have evolved which offer prevention of deformity and correction of existing deformities. These have been outlined briefly.

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Plan Now to Attend

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- *Labor Looks at Prepayment*
- *How Medicare Will Operate*
- *The Appalachian Commission's Health Objectives*
- *Medicine's Role in '66*

Massive Liver Injury and Shock

M. Atik, M.D.*
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Clinical material and experimental data are presented to indicate that the retention of devitalized liver tissue rather than loss of functional liver parenchyma is responsible for the severity of shock and high mortality associated with massive liver injury.

THE CONCERN over the increasing number of blunt liver injuries due to vehicular accidents with only a modest decrease in mortality in the past two decades forms the background of this report.

Clinical Experience

A review of 309 cases of liver injuries at Charity Hospital of Louisiana revealed blunt trauma to be responsible for 36 per cent of the cases, the rest being gunshot and stab wounds. The overall mortality for the group of patients with blunt liver injury was 55 per cent, while the mortality for the latter two groups were 21 per cent and 2.5 per cent respectively. An even higher mortality for severe blunt injury of the liver has been reported by Reeder from the cases collected at Louisville General Hospital.

This high mortality is partly explained by missed and late diagnosis, by the severity of trauma, and by the associated injuries as well as by delayed and inadequate surgery. The depth and extent of liver injury is usually not appreciated. The current surgical methods, while usually effective to control hemorrhage, by no means have solved the problem of intolerance of damaged liver to shock and of post-traumatic liver necrosis and infections. The severity and persistence of shock, despite apparent adequate blood replacement, are often out of proportion to the amount of blood loss seen at the operating table. Blood replacement, control of hemorrhage, and the copious use of antibiotics have not substantially changed the outcome of patients with massively traumatized liver.

To substantiate the intolerance of damaged livers to shock, and to assess whether the gravity of shock is due to the loss of functioning liver substance or related to the contribution of devitalized tissue, the following experiments were undertaken.

Experimental Observation

Under Nembutal anesthesia and the protection of antibiotics, a group of 16 dogs were subjected to laparotomy and ligation of the common hepatic artery. These animals survived and showed no apparent difference from another group of 16 dogs which were subjected to laparotomy only. There was no gross disturbance in the liver chemistries except for a transient elevated SGOT. A week later, all dogs were subjected to a standard hemorrhagic shock under Nembutal anesthesia. The animals were bled to a systolic pressure of 60 mm. Hg., and maintained at this level for one and a half hours.

The hepatic artery-ligated dogs reached this level and began to take up blood from the reservoir much earlier than their control counterparts, and showed profound and persistent acidosis and blood oxygen desaturation following hemorrhage. The blood gas data indicated that the acidosis is primarily metabolic. Serum catecholamine and guanase levels were three to five times higher in the hepatic artery-ligated than in the control animals. There were no significant differences in the BUN, NPN, lactic acid, and LDH, serotonin and histamine between the two groups of dogs. Thirteen of the dogs with hepatic artery ligation and only five of the controls died within 24 hours. There was good correlation between severity of acidosis and blood oxygen desaturation and survival of the animals.

†*Presented at the meeting of the Kentucky Chapter, American College of Surgeons on September 23, 1965 during the Kentucky Medical Association Annual Meeting in Louisville. Supported by Grant No. HE-09431, National Institutes of Health.*
**Associate professor of surgery at the University of Louisville School of Medicine, Louisville, Ky.*

Six other dogs were similarly subjected to hemorrhagic shock two weeks following 75 per cent hepatectomy. The mortality, hemodynamics and biochemical changes of these dogs were not significantly different from the control group. Only two out of six of these dogs died. The other four, at the time of sacrifice a week later, showed significant regeneration of their liver tissue (about 45 per cent of the original weight).

Discussion

These experiments confirm the clinical impression that shock is poorly tolerated by the damaged liver and that this intolerance is not due to the loss of functioning liver tissue. Indeed, partially hepatectomized dogs withstood shock almost as well as the controls.

The contribution of devitalized liver tissue to shock is of great significance; the extent of this contribution and the exact underlying mechanisms are poorly understood and are not as yet fully appreciated. Nevertheless, the data thus far obtained have been useful in formulating a different approach to the management of massive liver injury and shock. Based on our current concepts of shock and the experience at this medical center and elsewhere, the following recommendations appear to be justified:

1. Excision of all devitalized liver tissue when possible, even to the extent of partial or total hepatic lobectomy.
2. Control of hemorrhage by direct ligation of severed vessels rather than by packing.
3. Use of sump drains in the vicinity of the wound and in the subhepatic space.
4. Drainage of common bile duct in selected cases.
5. Pre-operative as well as post-operative use of antibiotics (including local irrigation of the wound with kanamycin).
6. Infusion of balanced salt solution before and during operation in addition to blood replacement.
7. Prompt treatment of acidosis concomitant with shock.
8. Use of mild hypothermia when major resection or temporary occlusion of important hepatic vessels is contemplated.
9. Continuous intravenous slow drip of low molecular weight dextran along with infusion of glucose and electrolyte solutions for 3—4 days.
10. Daily infusion of serum albumen until the remnant of the liver is able to synthesize an adequate quantity of it.

Summary

Massive injury of the liver due to blunt trauma is associated with persistent high mortality. Clinical experience and experimental observations indicate that the resultant devitalized liver tissue is mainly responsible for severity and persistence of shock and gravity of this form of injury. Removal of devitalized tissue by partial hepatectomy appears to be the only hope of improving the result. The current measures of management of shock and improved pre- and post-operative care should make this approach more feasible and rewarding.

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CASE DISCUSSIONS
From The
University of Kentucky Hospitals

Bullous Lesions in Anaphylactoid Purpura

G. T. Mruthyunjaya, M.B.B.S.*

Introduction

THE PURPOSE of this report is to emphasize that bullous lesions, though rare, can occur in children who have anaplylactoid purpura.

Case Report

K. H., an 8 year old white girl, was admitted to the University of Kentucky Medical Center ten days following the onset of vomiting, diarrhea, fever, sore throat and backache. Six days prior to hospital admission, she developed a transient, faint, generalized macular rash. Two days later she complained of hip and knee pain. Swelling of wrists and ankles was noted at that time. Two days prior to admission, a new maculopapular eruption appeared on the arms, legs, and buttocks. This rash progressed rapidly to hemorrhagic vesicles with central umbilication. On the day of hospital admission, she experienced nausea and abdominal pain followed by protracted vomiting, hematemesis and melena.

On physical examination at the time of admission, the patient appeared acutely ill, toxic and semi-prostrate. The temperature 102° F., pulse 160, respiration 24, and blood pressure 110/80. Deep and superficial vesicular hemorrhagic skin lesions with umbilication were present on the feet, ankles, legs, buttocks and arms. (Figures 1 and 2.) All the lesions appeared in the same stage of development; they were not pustular. Other pertinent findings included flat purpuric lesions on the upper eyelid and a 1-5 cm. hemorrhagic area on the right buccal mucosa. The chest was clear to ausculation and percussion, and no cardiac abnormalities were present. The abdomen was diffusely tender but no rebound tenderness was elicited; bowel sounds were active. Neither abdominal masses nor liver or spleen were palpable. Rectal examination revealed dark bloody stool, but no mass. The patient objected to passive movement of all joints, particularly of the fingers, although there was no swelling nor redness.

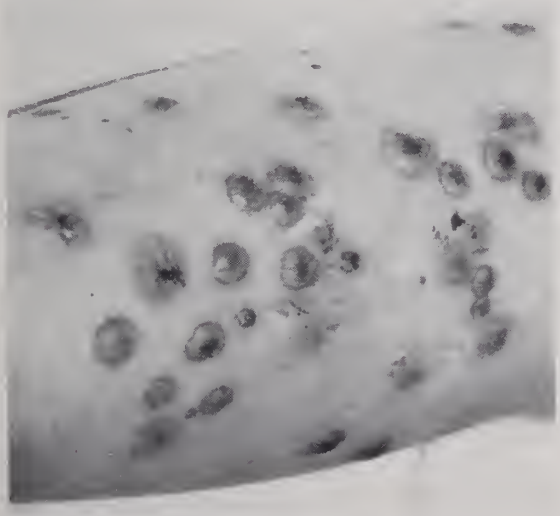


FIGURE 1. Antero-Lateral Aspect Of Left Leg Showing Vesicular Lesion With Umbilication. Second Hospital Day.

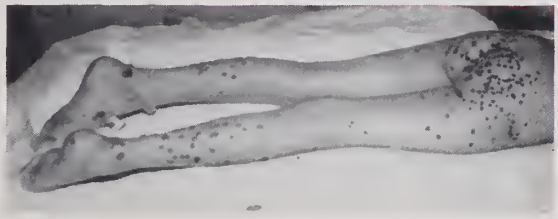


FIGURE 2. Dorsal Aspect Of Lower Limb With Lower Trunk Showing Distribution Of Skin Lesions. Second Hospital Day.

The results of the initial hemogram included a homoglobin of 17 gm.%, hematocrit 52%, white blood cell count 35,000/mm^3 with 76% neutrophils, 19% lymphocytes, and 6% monocytes; platelet count 500,000/mm^3; bleeding and clotting times were normal. Serum urea nitrogen was 34 mg.%; serum electrolytes and blood sugar were within normal limits. Serum electrophoresis showed the concentration of haptoglobin to be increased. Serum albumin and transferrin concentrations were decreased. Serum immune globulin and B_1C globulin concentrations were normal; this pattern was consistent with an acute inflammatory process.

Cultures of blood and spinal fluid grew no bacteria. A naso-pharyngeal culture grew no Group A streptococci; a culture of vesicular fluid grew one colony of staphylococcus. A touch preparation of an unroofed vesicle showed no cells containing inclusion bodies nor elementary bodies. Acute and convalescent phase sera showed no antibody against smallpox, chicken pox and herpes simplex. The serum antistreptolysin

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FIGURE 3. Medial Aspect Of Left Ankle Showing Purpuric Lesion On Ninth Day After Admission.

0 titre was 0-10 units. A punch biopsy of the edge of an intact hemorrhagic vesicle was taken on the fourth hospital day. This showed a central necrotic area which was composed of fibrin and polymorphonuclear cells. At the margin, occasional perivascular leucocyte infiltration was noted, and endothelial proliferation was also noted. In view of the marked necrosis, the underlying vascular changes were seen only at the margin.

Hospital Course

For two days after admission, the patient's toxic appearance was unchanged, and continued abdominal pain at times suggested intussception. Initial treatment consisted of nasogastric suction, intravenous fluids, and chlorpromazine. The hematocrit on the third day had dropped from 52 to 38%. By the fourth hospital day, the child's condition was much improved, the abdominal pain was no longer present, the diarrhea decreased, and intravenous fluid therapy was discontinued. Over the next five days, the vesicular lesions became crusted and fell away, leaving in a few areas a typical "pox" scar. On the ninth day, new cutaneous manifestations occurred in the form of a flat rash on the feet as shown in Figure 3. At this point it became clear that the patient did indeed have anaphylactoid purpura. There were no recurrent abdominal or joint manifestations; however, microscopic hematuria (20 RBC/hpf) and proteinuria (1+) occurred on the eleventh and twelfth days. The patient remained normotensive, serum urea nitrogen was not elevated and urine analysis was subsequently normal. The child was discharged on the fourteenth day and remained on restricted activity until return to the hospital.

The patient was followed up for reevaluation of kidney status by readmission and outpatient visits for six months. No renal dysfunction was found.

Comment

The usual skin eruptions and other features of this disease are well described by Allen, Diamond, and Howell[1]. The characteristic sites of distribution are the ankles, legs, buttocks, genitalia, extensor surfaces or arms and occasionally the face and ear lobes. Skin manifestations in anaphylactoid purpura are characterized typically by erythematous macules or papules which may look like urticaria at first. Within a few hours to days they become hemorrhagic in the central areas. They later become dark purple and they do not blanch on pressure. Fading of the lesions to a brownish color occurs slowly and the lesions disappear in two to three weeks. The standard pediatric texts and review articles do not mention vesicular lesions as part of the picture of anaphylactoid purpura. Bilaloglu[3], however, recently published a photograph of a child with this disease which showed hemorrhagic bullous lesions very similar to those of our patient. Skin biopsy at the site of the lesion shows perivascular infiltration with polymorphonuclear leukocytes in the small vessels of the dermis, with plugging of fine vessels by leukocytic platelet thrombi. This typical skin lesion with its histological features was first described by Gairdner[2].

Our case had the distribution of lesions described above. At one stage, they were pox-like, and not typical of anaphylactoid purpura. The subsequent course of the patient with joint and abdominal involvement and the recurrence of the rash, this time typical of anaphylactoid purpura, made the diagnosis clear. The histologic picture of the biopsy was quite compatible with this diagnosis.

Early in the course of the child's illness hemorrhagic chickenpox, smallpox, coxsackie A^{16} infection, and Rocky Mountain spotted fever were considered. In fact, the absence of descriptions of bullous lesions in anaphylactoid purpura led us away from this diagnosis, although the history and the joint and abdominal findings were highly suggestive. Late in the course of the illness, it becomes very clear that the picture was that of anaphylactoid purpura. The laboratory data did not support the other diagnostic possibilities.

Summary

1. In anaphylactoid purpura, the typical skin manifestations are urticarial, macular, and maculopapular. However, patients can present with a pox-like eruption with umbilication, as our's did.

2. Our patient's skin lesions showed the same histologic features as those which have been described in the typical non-vesicular lesions of anaphylactoid purpura.

I am indebted to Dr. Haeberle, of Russell, Kentucky, for referring the case to UKMC, and also Dr. Kenneth L. Herrimann, Communicable Disease Center, Laboratory Branch, Atlanta, Georgia, for helping with viral studies. I am also indebted to Dr. Duane Tweeddale for his interpretation of the biopsy specimen and to Dr. Phillip Holland for help in preparing the manuscript.

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SPECIAL ARTICLES

Medcap to Phou My†

GEORGE F. BROCKMAN, M.D.
Greenville, Ky.

WHEN circumstances permit the medics of the Vietnamese Popular Forces, corresponding more or less to the U.S. National Guard on active duty, organize expeditions for the provision of medical care to isolated villages. Tremendous stocks of a few medications are carried out to the village for a sick call, which is attended by the U.S. hospital corpsmen who are counterparts of the Vietnamese medics.

Sergeant Carroll, of Military Advisory Command, Vietnam, came for me at eight. His jeep was sandbagged against mines and loaded with medical supplies. Sergeant Slaton, (formerly of Madisonville), an engineer, was accomplishing double duty by riding shotgun and inspecting the public works of the village.

We proceeded over a well-secured highway to Thu Thua, district headquarters. Here we acquired two Vietnamese corpsmen, Sergeant Spaulding, the subsector medic, and two female VN civilian health workers. These came with their own Jeep, and an additional gunnery sergeant, with his assistants, added fire-power. By nine a.m. the morning sweep had reported the road clear to Phou My.

The road was typical secondary road, but with one almost impassable (even for four-wheel drive Jeeps) mud hole. With everyone pushing in turn, we got them through for the last two miles. Phou My is on detailed maps only, but it is on the bank of a navigable canal. It is the last outpost, as the far shore of the canal is Zone D, conceded to the Viet Cong. Our road had been through Zone C—classified as usually belonging to the Viet Cong, unless we care to make the effort, as today, of assuming control of a local area.

Phou My looks like the pictures of the isolated pacified villages. There is a very thorough belt of barbed wire, with carefully designed access road, channelling incoming traffic into enfiladed machine gun posts.

Everybody and his brother were there to welcome us. The medics established a dispensary in an abandoned house, and for four hours were swarmed by over 250 men, women and children. Their medication included U.S. Army diarrhea pills, worm medicine, and some antibiotics, with a little store of ear drops, and a large store of soap. Their most popular business was with vitamin pills, also available in large quantity through the donation of a native magnate at Tan An. In view of the crowd, they apportioned not over 10 doses of medicine to any one patient.

The most impressive single treatable condition was chronic otitis media in children. The medics report that it is always present, even though the area is strictly tropical. Treatment is cleansing, antibiotic ear drops, penicillin by injection, and oral antibiotics, which should be quite effective.

War injuries were the most important part of the clinic for the physician. Two well-healed gunshot wounds of the femur were found to have been followed by poor functional results, apparently because of the constant pressure on hospital beds caused by the constant influx of fresh casualties. We reinforced the instructions of the medics with reference to rehabilitation physical therapy. If they can exert the self-discipline to carry out the simple exercises prescribed, they should secure excellent functional results .Little could be offered, however, for a chronic purulent sinus secondary to a mortar fragment wound of the maxilla. We gave him a tremendous dose of penicillin, and a week of broad-spectrum antibiotics.

There was no shortage of truly sick children. One child had empyema following a measles pneumonia, and I doubt that our three days' prescription for intensive treatment will alter the outcome. One emaciated infant, with moderate chronic jaundice and bilateral cataracts, brought back some vague memories of diseases due to inborn errors of metabolism, but I feel sure a pediatrician would not have altered the probable course of the disease with the tools at hand.

While the sick, lame and lazy were on hand at the dispensary, the well, or the treated, were hanging

† *Doctor Brockman, speaker of the KMA House of Delegates, recently spent two months in Vietnam as a member of a voluntary medical team providing medical care to the civilian population of that country, serving under the auspices of Project Vietnam. This account of one day's events was written by Doctor Brockman during his stay. The Editors of* The Journal *feel that it will be of interest to all KMA members.*

from the rafters in a straw-thatched hut that had been darkened for the projection of a Walt Disney animated cartoon on the spread of hook-worm. The four o'clock audience of the TV cartoon hour is no more attentive.

The most outstanding part of the performance was given by the Army medical sergeants. While every effort is made to have the show as a Vietnamese one, the medics are encouraged to attend to help in the education of their Vietnamese counterparts. The medics I was with were well experienced with nasty combat casualties and death. This did not prevent their use of a truly maternal gentleness in cleansing the dirty ear of a screaming child for a foreign body, in the 95-degree temperature of a thatched hut filled with clamoring Vietnamese.

Sick call was completed when the medications were exhausted, not when the last patient had been treated. The total number treated was something over 250.

Because Phou My is literally at the end of the road, our return was by necessity over the same route. This is regarded as poor maneuvering for Zone C, as the Viet Cong also know that what goes out must come in by the same route, and have many times mined and ambushed parties such as ours on the return trip. Our return was uneventful, except that the sub-sector commander, concerned because we had not returned as soon as planned, had stuck in the same mud-hole that had bothered us on our way out. With only a private as help, he had lacked the manpower to push through, and found himself immobilized in unfriendly territory. In getting his vehicle out of trouble, our clustering of four Jeeps attracted a couple of casual and ineffectual sniper shots, which served to expedite the manhandling of the vehicles.

The physician on such an expedition as this may well feel that he personally has contributed little to the care of patients or to the shortening of the war. He may have been able to help the sergeants a little in their thinking about pediatrics, and some of the combat cripples may persist in their rehabilitation. But with no diagnostic or therapeutic backup, what is three days of medication worth to the assortment of disease he saw? Some of the ears will fortunately heal, possibly a pneumonia or two will make it because they happened to be ill at the time medicine was available. The total medical accomplishment is little. But Vietnamese and American, civilian and medical, all unite in feeling that the offering of even a little medical care to a people who have never had any is winning the minds of the populace from the Communists with a weapon they cannot match.

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EDITORIALS

To Upgrade Health Legislation

ON DECEMBER 20th, 1965 the Jefferson County Medical Society had its usual social meeting featuring a dinner to which the wives of all members were invited, and a program of entertainment offered by the Medical Auxiliary. To this function were invited all State Legislators of the Third District with their wives. Individual County Society Members and their wives acted as host and hostess for the visiting couples. This proved to be a very informative and stimulating experience for all concerned.

It was a real pleasure to have an evening with the Senators and Representatives from our district, to meet their wives, and to discuss matters of mutual local interest. We found these elected officials to be generally men of character, education and refinement who had offered their services to the Civil Government at personal sacrifice of time and income in their respective businesses and professions. This group of seven Senators and 17 Representatives did not include a single physician. Maybe we should be a little ashamed that men of achievement and stature from many other walks of life have been more generous in offering their services to the state than have we.

Among the 138 members of the 1966 Kentucky General Assembly—38 Senators and 100 Representatives—there are one physician, one dentist, one pharmacist and one chiropractor. This is a poor representation of the healing professions when so much of the proposed legislation affects the health and general welfare of our people. We are very proud of Doctor Mitchell Denham from Maysville for his six years of devoted service and for the stature he has attained as an effective legislator. We recall the splendid service of Doctor Shields from Shelbyville, Doctor Johnson from Pikeville and Doctor Sanders from Dorton who during the past 20 years have so well concerned themselves with matters of health legislation.

The medical profession is better represented in our Federal than in our State Government. We are happy and proud to have Doctor Tim Carter from Tompkinsville honoring us in Washington. Physicians are well educated, civic minded and effective in all forward-looking local and state matters, but unfortunately they are seldom politically inclined. That is to be regretted. It is true that the demands on their time are great and they are engaged in work that they and their clientele regard as more urgent and important than politics or the desire to hold office or shape legislation. With so much which pertains to health before every assembly or Congress for consideration perhaps we should make a reappraisal of our obligations—more physicians may well offer themselves for elective offices.

To have wider interest in health legislation and to be in a better position in providing information to our legislators, K.M.A. has this year undertaken a systematic legislative contact system through key men in every district and county. To each Senator and Representative is assigned a physician from his own locality, preferably an acquaintance and friend and, when possible, a member of the same political party. Hopefully a physician so assigned is at the service of his Senator or Representative to offer or furnish information and medical opinion relating to any pertinent issue. The same type of service is offered to our national Senators and Representatives.

John C. Quertermous, M.D., of Murray, is chairman of the National and J. Campbell Cantrill, M.D., of Georgetown of the State Committee. Additional members of the Council on Legislative Activities are: B. B. Baughman, M.D., Frankfort; Daryl P. Harvey, M.D., Glasgow; Hoyt D. Gardner, M.D., Louisville;

Gabe A. Payne, M.D., Hopkinsville; and David B. Stevens, M.D., Lexington. A key man is appointed for every Senatorial and Representative District—and a physician to each individual legislator.

Admittedly this is a large, rather loosely cohesive and somewhat cumbersome vehicle through which to influence legislation, and will be effective only to the extent that the participating physicians are alert and energetic. It could be greatly helped also by those who are not assigned as key men but who have acquaintances in the legislatures and a knowledge of and active interest in the issues at stake. The planning and organization thus far show promise of good returns.

There is now before Congress a bill, HR 5191, which if passed into law would seriously handicap experimentation and research in all medical schools and laboratories for medical investigation. Some intent of this bill we approve, but if enacted in its present state it would be an impediment to progress. Our Council on Medical Activities after due study has decided to oppose the measure and to use our established channels to inform our Senators and Representatives in the United States Congress of the unfavorable consequences of its passage.

It is too early to know what measures affecting health will be proposed in our 1966 State legislature. Some that are anticipated are the Nurses Bill, a Coroners Bill, a Pharmacy Bill, a Restaurant Bill, and measures affecting P.K.U. detection tests, garbage disposal, sewage, air and water pollution. So far as information can be had relative to these and other measures not yet defined, it will be studied carefully and a constructive opinion formed from which our position as guardians of health may be made known to our legislators.

Mr. Gilbert Armstrong is our official representative in Frankfort, and it is principally through him and his aides that we must hope to have adequate advance information.

For too long we as physicians have been relatively insensitive to legislation in the making. Influence if at all effective must be exerted there. It would be well for us all, key men or not, to be intelligently alert to whatever changes are proposed and to help wherever we can in procuring the best type of health legislation for our people.

SAM A. OVERSTREET, M.D.

Senior Day

PREPARATIONS are now being completed for the presentation of this year's annual KMA Senior Day Programs. This marks the twelfth consecutive year that KMA has sponsored this program for the University of Louisville senior medical students and the third annual program for senior medical students at the University of Kentucky. These programs would not have enjoyed the success they have without the much appreciated cooperation of the local medical schools and county medical societies.

Each year a number of Kentucky physicians take two entire days from their already crowded schedules to participate in the traditional KMA Senior Day Programs. Realizing that great challenges face the new M.D. after his years of studying and schooling, participants in the Senior Day Program strive to assist the senior students in this transition from the academic phase of medicine to the early stage of actual clinical practice.

Much time and effort has been spent securing competent speakers who present appropriate material which has been found to be so helpful in the past. Among the presentations medical students in the two schools will hear are "Where You Practice," "Human Equation in Medical Practice," "The Mechanics of Setting Up a Practice." The student will also learn of his civic and legislative responsibility.

Since this is one of the first exposures of the medical student to organized medicine and its rule in the profession and society, the Senior Day Programs have proved to be of substantial educational value. We wish to express our full appreciation to all those KMA members who are contributing to these worthwhile programs.

All KMA members are invited to attend.

FRED C. RAINEY, M.D., CHAIRMAN
KMA SENIOR DAY COMMITTEE

ORGANIZATION SECTION



Doctor Slagle



Doctor Huntley

Utilization Review Discussion Slated for Interim Meeting

How Utilization Review committees will operate under PL 89-97 will be the opening and one of the top features of the 16th Annual Interim Meeting to be held at DuPont Lodge, Cumberland Falls, April 13 and 14.

According to KMA president Everett H. Baker, M.D., Louisville, this matter will be explored by a panel composed of top officials of the Social Security Administration, a former president of the Kentucky Hospital Association, a highly knowledgeable executive of Blue Shield, and an authority from the AMA's Council on Medical Services.

The following morning, nationally recognized experts will consider the high points of PL 89-97 (Medicare) and voluntary prepayment plans as viewed by labor.

The program committee, since the conference is to be held in the Appalachian region, will have two short presentations on the Appalachian Regional Health Commission and its objectives. These will be followed by an hour-long question and answer session.

The conference theme is the role of medicine in 1966. This also will be the subject of the closing luncheon speech by James Z. Appel, M.D., Lancaster, Pa., president of the AMA, Doctor Baker said.

The medical participant on the Wednesday evening panel will be George W. Slagle, M.D., of Battle Creek, Mich., a member of the AMA Council on Medical Services and vice-chairman of its Committee on Insurance and Prepayment Plans.

A member of the AMA Advisory Committee on Physician Participation to the Social Security Administration since October, 1965, Doctor Slagle is a former president of the Michigan State Medical Society and has been a member of the Board of Directors of the Michigan Society of Internal Medicine since 1962. He is also chairman of the Board of Governors of the University of Michigan Medical Center Alumni Society.

Presenting the objectives of the Appalachian Regional Commission on Thursday morning will be Robert R. Huntley, M.D., Washington, D.C., co-director of the staff of the Health Advisory Committee of the Commission. Doctor Huntley has held this post since last October.

He is an assistant professor in preventive medicine and medicine at the University of North Carolina, and a 1951 graduate of the Bowman Gray School of Medicine. Doctor Huntley is a member of a number of medical societies, including the American Federation for Clinical Research and the Association of Teachers of Preventive Medicine.

KMA Announces Program Plans For Med School Senior Days

KMA Senior Day Programs will be held again this year for the University of Louisville senior medical students on March 21 and the University of Kentucky medical students April 12, Fred C. Rainey, M.D., Elizabethtown, Senior Day Committee Chairman, announced recently.

Doctor Tom Haggai, a minister from High Point, North Carolina, will be the principal speaker at the University of Louisville program, according to Doctor Rainey. Other presentations will be made by KMA members and officers, who will also speak at the University of Kentucky event. Further details concerning Doctor Haggai and his presentation will be presented in the March issue of *The KMA Journal.*

This year's program at the University of Louisville will be the twelfth presented at the school by KMA in cooperation with the Jefferson County Medical Society and the School of Medicine.

The Third Annual Senior Day Program at the University of Kentucky will be presented by KMA, cooperating with the UK College of Medicine and the Fayette County Medical Society. Both programs will close with a dinner for the seniors. Doctor Rainey said the cooperation of the medical schools and county medical societies make a valuable contribution to this program and is appreciated by the KMA Senior Day Committee.

KMA Lists Two New Members

Two physicians from Boone County are new members of KMA, according to membership records dated December 16. They are Glenn F. Baird, M.D., Florence, and John D. Ammon, M.D., Hebron.

Dental Insurance Corporation Formation Readied by KDA

A dental-insurance plan, similar to Blue Shield, will soon be offered to Kentuckians as the result of the formation of the Kentucky Dental Service Corporation (KDSC) by the Kentucky Dental Association, it was announced recently by A. B. Coxwell, D.M.D., executive secretary of KDA.

Doctor Coxwell said that the Association is now awaiting approval from the Kentucky Commissioner of Insurance of its application to form the corporation, which is similar to those already in operation in several states. Basically a service plan, KDSC will for the time being offer only group prepaid plans. It is expected that individual policies will be offered later, when the dental service plan gains more experience.

Dental services to be made available will range from "Basic Preventive Dentistry"—fillings, x-rays, cleanings, and extractions, to "Comprehensive Dentistry"—crowns, bridges, surgery, and plates. Premiums on the basic dentistry policy, Doctor Coxwell estimated, will be about $6 per month for a family.

In order to ensure availability of services, law requires that 51 per cent of the dentists in a county must agree to participate in the plan. Doctor Coxwell said that approximately 97 per cent of the dentists in Kentucky have indicated that they will support the plan.

The KDSC, a nonprofit, nonstock corporation, will operate separately from the Kentucky Dental Association, and will have a separate board of trustees composed of 14 dentists and seven laymen. It is expected that dental care in the state will double when insurance is made available to more people.

KMA Key Man Orientation Course Held Jan. 12 at Louisville

Attendance at the KMA Legislative Key Man Orientation program Wednesday, January 12 at Louisville was described as exceptionally good by the co-chairmen of the KMA Council on Legislative Affairs. John C. Quertermous, M.D., Murray, is chairman for National Affairs, and J. C. Cantrill, M.D., Georgetown, is chairman for State Affairs.

The morning program was devoted to an explanation of the new expanded Legislative Key Man booklet, and to a discussion of legislation that had been or probably will be introduced at the 1966 Kentucky General Assembly.

The conference was concluded with a stimulating talk by Ernest B. Howard, M.D., assistant executive vice-president of the AMA, Doctor Quertermous said. Doctor Howard gave a penetrating discussion of the legislative climate we now face and made suggestions for effective participation by Key Men in influencing enactment of legislation in the public interest. (See editorial on page 149.)

SE Surgical Congress to Meet

A number of distinguished national medical authorities will speak at the annual session of the Southeastern Surgical Congress February 28-March 3 at the Marriott Motor Hotel in Atlanta, according to J. Duffy Hancock, M.D., Louisville, councillor for Kentucky.

Doctor Hancock announced that several symposia will be presented as a part of the separate programs planned for physicians and nurses.

Seventh Trustee District Plans Program of Feb. 23 Meeting

The Seventh Trustee District of KMA, comprised of ten counties in the north central section of the state, will hold its district meeting on Wednesday, February 23, according to Donald Chatham, M.D., Shelbyville, trustee for that district.

KMA president Everett H. Baker, M.D., will share the program with Richard F. Greathouse, M.D., Louisville, secretary of the Kentucky Educational Medical Political Action Committee. The meeting will be held at the historic Science Hill Restaurant in Shelbyville, formerly a well-known girls' preparatory school.

Doctor Baker's subject will be "The Physician in 1966". Doctor Greathouse's topic will be "KEMPAC's Opportunities in '66".

Doctor Chatham said he was arranging other features which, it was felt, would be attractive to the wives of physicians. Individual invitations have been sent to members of the Seventh Trustee District.

M.D.s Alerted to Law Change Regarding Drug Records

The attention of KMA members is directed toward the provisions of Public Law 89-74, which became effective February 1, 1966. The purpose of the law is to curb drug abuse through the curtailment of illicit drug traffic.

According to C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association and former counsel of the AMA, there has been some confusion as to what records a physician must keep. Putting it simply, he says, "They are not required to keep records as a consequence of this law unless, in the course of their practice, they dispense the drugs referred to and charge for them."

According to Mr. Stetler, the precise wording of the Act relating to record-keeping follows: "The provisions of paragraphs (1, Records) and (2, Inspection) of this subsection shall not apply to a licensed practitioner . . . with respect to any depressant or stimulant drug received, prepared, processed, administered, or dispensed by him in the course of his professional practice, unless such practitioner regularly engaged in dispensing any such drug or drugs to his patients for which they are charged, either separately or together with charges for other professional services."

Ky. Ob-Gyn Society to Meet

The Kentucky Obstetrical and Gynecological Society will hold its annual meeting April 14-16 at the Netherland-Hilton Hotel in Cincinnati, according to a recent announcement. Panel discussions and individual papers will be presented by members and guest speakers. Further information will appear in later issues of The Journal.

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Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

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Three KMA Trustee Districts Set Annual Meetings for April

Three KMA trustee district meetings have been scheduled for the month of April, according to information on record at press time.

The Thirteenth District will hold its meeting April 5 at Ashland, Walter L. Cawood, M.D., Ashland, district trustee, has announced.

The meeting of the Eighth District will be held at Covington on April 7, according to an announcement by W. Donald Janney, M.D., Covington, trustee for that district.

A meeting of the Fifth District, to be held in conjunction with that of the Jefferson County Medical Society at the Medical Arts Building in Louisville on April 18, is being planned by A. O. Miller, M.D., Fifth District trustee, and Hoyt D. Gardner, M.D., JCMS president.

Members of each district will receive individual invitations to their respective meetings several weeks before the meeting.

Diabetes Association to Sponsor Camp for Diabetic Children

The Kentucky Diabetes Association will sponsor its first camp for diabetic children at Kentucky Lake in August of this year, James Robert Hendon, M.D., Louisville, camp committee chairman, has announced.

Youngsters from Kentucky and surrounding states will be accepted for a fee which has not yet been determined, Doctor Hendon said. The age range will be from 9 to 15 years. Two two-week sessions, one for boys and one for girls, are being planned for Camp Running Deer at Kentucky Lake. The Jefferson County Lay Diabetes Society is helping with arrangements.

Other members of the camp committee are Ben Hollis, M.D., Harold Eskind, M.D., Kenneth Crawford, M.D., and Elbert Christian, M.D., all of Louisville; David Lewis, M.D., Elizabethtown, and C. C. Mabry, M.D., Lexington.

Application and inquiries should be sent to camp headquarters, 410 Fincastle Building, Louisville, Ky. 40202.

Ky. Surgeons to Meet in April

April 8 and 9 are the dates of the scientific program of the Kentucky Chapter, American College of Surgeons to be held at Lexington in cooperation with the department of surgery at the University of Kentucky, Charles M. Edelen, M.D., Louisville, chapter president, has announced. Ben Eiseman, M.D., chairman of the department at U. of K., is in charge of the Friday program.

A business meeting beginning at 8:00 p.m. the evening of April 7 will precede the scientific program, which ends at noon on Saturday. Featured as guest speakers on the program will be William A. Altemeier, M.D., professor and head of the department of surgery at the University of Cincinnati; J. William Hillman, M.D., chief of orthopedic surgery at Vanderbilt; and C. B. Mueller, M.D., chairman of the department of surgery at the State University of New York Upstate Medical Center at Syracuse.

Conference on Medical Education Held at Park Mammoth Resort

Approximately 60 physicians representing KMA and Kentucky's two Medical schools attended the January 21-23 Conference on Medical Education held at Park Mammoth Resort, Henry B. Asman, M.D., Louisville, KMA secretary and general chairman of the conference, reported.

The purpose of the meeting was to discuss matters of mutual interest to KMA and the medical schools, co-sponsors of the conference, Doctor Asman said. The sessions featured both formal presentations and group discussions.

A well-received discussion of the admission policies of the two schools was presented by Roy K. Jarecky, Ed.D., associate dean of admissions at the University of Kentucky College of Medicine, and Charles F. Wagner, Ph.D., associate dean and director of admissions at the University of Louisville School of Medicine. Kentucky is the second state to sponsor such a conference.

Lexington Clinic Conference Scheduled for Mar. 31

"Treatment of Convulsive Disorders" will be the topic of J. G. Rushton, M.D., consultant in neurology at the Mayo Clinic, Rochester, Minn., main guest speaker at the Eleventh Annual Clinical Conference to be held by the Lexington Clinic on March 31.

Doctor Rushton's paper will be one of a series of presentations on convulsions making up the program for the morning session, which begins with registration at 8:30 a.m. The afternoon session will consist of five papers on various topics such as "Cardiac Pacemakers", "Chemotherapy in Malignancy", and "Conception Control".

Hugh S. Fulmer, M.D., associate professor of community medicine at the University of Kentucky College of Medicine, will speak at the luncheon, to be held at the Clinic, on "The International Community Medicine Clerkship at the University of Kentucky Medical Center". Other speakers from the College of Medicine, as well as staff members from the Lexington Clinic, will present papers during the scientific sessions.

Approval from the American Academy of General Practice for continuation study credit has been requested.

Dr. Stewart Heads Pathologists

Wellington B. Stewart, M.D., professor and chairman of the department of pathology at the University of Kentucky, was installed as president of the Kentucky Society of Pathologists at its December 11 meeting in Louisville.

Doctor Stewart succeeds E. J. Fadell, M.D., Louisville. Harold Resinger, M.D., Lexington, was named president-elect, and John D. Allen, M.D., Louisville, is secretary-treasurer.

Utilization Review Committees Subject of Feb. 17 Program

Utilization Review Committees, their formation and functions, will be the topics of an Institute co-sponsored by KMA, the Kentucky Hospital Association, and Blue Cross-Blue Shield on February 17 at the Executive Inn in Louisville.

Vergil N. Slee, M.D., director of the Commission on Professional and Hospital Activities, Ann Arbor, Mich., will discuss the Medical Audit Program and Professional Activities Study covering such subjects as "Utilization Review and Medical Auditing".

Everett H. Baker, M.D., Louisville, KMA president, and W. Leon Hisle, Berea, president of the Hospital Association, will present the viewpoints of their organizations. Other speakers will be representatives of the American Medical and Hospital Associations and Kentucky Blue Cross-Blue Shield, whose names have not been announced.

The institute is designed for chiefs of medical staffs, hospital administrators, directors of nursing, and chief medical record librarians.

Sixth Trustee District Meeting Held Jan. 11 at Franklin

John C. Quertermous, M.D., chairman for National Affairs of the KMA Council on Legislative Activities, was one of the participants on a panel discussion featured at the Sixth KMA Trustee District Meeting January 11 at Franklin, according to Rex E. Hayes, M.D., Glasgow, district trustee.

Other panelists on the program prepared by Paul J. Parks, M.D., Bowling Green, and L. F. Beasley, M.D., Franklin, were the presidents of the district Dental and Pharmaceutical societies.

Among important matters under discussion were legislative developments relating to medicine in the state legislative session, Doctor Hayes said.

A Growing Menace—

Dr. Wallace Reports to Board On AMA Conference on VD*

A tactical maxim of military science advocates total destruction of the enemy's capability to resist. We, in the health field, failed to apply this principle in our efforts to eliminate the problem of venereal disease. Because of this, the incidence of infectious syphilis has been increasing and the disease threatens to reestablish itself as a major public health problem.

In recognition of this threat, the American Medical Association's Committee on Environmental and Public Health with the assistance of the U.S. Public Health Service and the American Social Health Association, conducted a national symposium on venereal disease in November, 1965. All three organizations called for a broad educational campaign to inform not only the general public but professional groups of the problem.

Two general areas of activity were emphasized at the symposium: the importance of educational efforts directed toward the teen-age population and the encouragement of reporting of infectious syphilis by physicians in order that epidemiological follow-up can be undertaken. The epidemiological follow-up is designed to break the chain of transmission by identifying the infecting source and other possible contact cases.

To assist in teen-age education, a programmed course of instruction has been developed. This course may be presented in three one-hour sessions and is designed for insertion into the health courses provided junior and senior high students. Further information on the program can be obtained from your county health department or the Kentucky State Department of Health, Venereal Disease Control, 275 East Main Street, Frankfort, Ky.

**This report was prepared by Thomas S. Wallace, Jr., M.D., director of Health for the Louisville and Jefferson County Department of Public Health. Doctor Wallace reported on the same subject to the KMA Board of Trustees at the December 9 Board meeting.*

Occupational Health Program Set

The Second Annual Governor's Conference on Occupational Health will be held on March 28 at the Brown Hotel in Louisville, according to Gradie R. Rowntree, M.D., Louisville, Conference chairman. John E. Eckerle, M.D., Louisville, is program chairman.

More than 200 persons are expected to register for the Conference, Doctor Rowntree estimated. More details on the program will be published in The Journal when they become available.

U.K. to Hold Newborn Seminar

"A New Look at the Newborn" will be the theme of the Fourth Annual Postgraduate Seminar to be presented by the department of pediatrics of the University of Kentucky College of Medicine on March 24-26.

The seminar is primarily directed toward the practicing pediatrician and physicians concerned with the care of the newborn. Registration will be limited to 40. A fee of $35 will be charged. For further information write to Warren E. Wheeler, M.D., chairman of the department.

AMA Holds Session on PL 89-97

L. Douglas Atherton, M.D., Louisville, chairman of the KMA Committee on Governmental Medical Services, and a member of his committee, Paul J. Parks, M.D., Bowling Green, attended an AMA-sponsored conference in Chicago January 20 and 21 on the public assistance programs offered under PL 89-97, the Medicare bill.

The conference was devoted specifically to Title XIX of PL 89-97, which is one of the areas of interest to Doctor Atherton's committee.

Blue Shield Reports Gains In Enrollment, Benefits

The National Association of Blue Shield Plans, coordinator of the 85 Blue Shield Plans in the United States, recently reported record gains in enrollment and benefits during the first nine months of 1965.

Membership for the third quarter reached 57,286,-041 —up more than a million over the 1964 year-end total. Benefits paid to subscribers were $1,017,491,063 during the first three quarters, a gain of $89,648,818 over the same period for 1964. Experts feel certain that the year's total will break the 1964 record of $1,241,856,467.

Following urging by the American Medical Association to "play an important role in administering the Medicare Law", Blue Shield representatives were appointed to serve on work groups established by the Social Security Administration to assist in drafting carrier criteria and regulations for Part B., the Supplemental Medical Insurance Program.

Almost all Blue Shield Plans have signified their interest in serving as carriers and most have resolutions from their local medical societies expressing their preference for Blue Shield. It is estimated that 56.2 per cent of all U.S. Government employees are Blue Shield subscribers.

NEWS ITEMS

John W. Scott, M.D., retired Lexington physician, was presented the first "Distinguished Alumnus Award" of the Lexington Area Alumni Chapter of Centre College at a dinner held by the group in December. Doctor Scott, 90, graduated from Centre in 1893. He was the recipient of KMA's Distinguished Service Award in 1952, and was a member of the KMA Board of Trustees for many years.

Dennis A. Brown, M.D., has recently become associated with **Philip B. Schworer, M.D.,** at Florence, for the practice of general medicine. Doctor Brown was graduated in 1959 from the University of Louisville School of Medicine and interned at St. Elizabeth Hospital, Dayton, O.

James W. Bard, M.D., a dermatologist, is now practicing in Lexington at the Lexington Clinic. Doctor Bard graduated in 1958 from Marquette University School of Medicine and interned at Yale University Hospital before completing his residency at the Mayo Clinic in 1965. From 1959-1962 he served in the U.S. Army Medical Corps.

John J. Wernert, Jr., M.D., has begun the practice of psychiatry in Louisville in association with **Joseph Goldstein, M.D.,** and **Presley F. Martin, M.D.** A 1958 graduate of the University of Louisville School of Medicine, Doctor Wernert interned at St. Joseph Infirmary in Louisville and completed his residency at the University of Louisville. He is former superintendent of Frankfort State Hospital and School.

(More News Items on Page 174)

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meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

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even when complicated by anxiety, tension, insomnia, agitation or rumination.

- **Acts rapidly.**
- **Side effects at recommended dosage infrequent, usually easily controlled.**

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

FEBRUARY

16 Obstetrics for General Practitioners. 9:00 a.m.—4:00 p.m., University of Kentucky Medical Center.

16-17 Health Sciences Communications Workshop; Univeristy of Kentucky Medical Center

23 KMA Seventh Trustee District Meeting, Science Hill Inn, Shelbyville

MARCH

2 Professor's Day, University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

21 KMA Senior Day, University of Louisville School of Medicine, Rankin Amphitheater

24-26 Fourth Annual Seminar of Department of Pediatrics, University of Kentucky Medical Center

28 Governor's Conference on Occupational Health, Brown Hotel, Louisville

30-31 Heart Association of Louisville and Jefferson County 12th Annual Symposium on Cardiovascular Disease, Brown Hotel, Louisville.

31 11th Annual Lexington Clinic Conference, Lexington; 8:30 a.m.

APRIL

5 KMA Thirteenth Trustee District Meeting, Ashland

5-8 Kentucky Dental Association Annual Meeting, Louisville

6 Professor's Day University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

7 KMA Eighth Trustee District Meeting, Covington

8-10 Ky. Chapter, American College of Surgeons, Lexington

12 KMA Senior Day, University of Kentucky Medical Center, Lexington

13-14 KENTUCKY MEDICAL ASSOCIATION Interim Meeting, Cumberland Falls

14-16 Kentucky OB-GYN Society Annual Meeting; Netherland Hilton Hotel, Cincinnati

18 KMA Fifth Trustee District Meeting, Medical Arts Building, Louisville

21 Kentucky Thoracic Society Annual Meeting, in conjunction with Kentucky TB & RD Association Meeting, Rankin Amphitheater, Louisville General Hospital

25-28 Kentucky Hospital Association Annual Meeting, Louisville

28 Ky. Chapter, Arthritis Foundation, Symposium on Rheumatic Disease, Co-sponsored by U. of L. School of Medicine. At Rankin Amphitheater, Louisville General Hospital

MAY

2-6 Symposium on Cardiovascular Disease, University of Kentucky Medical Center

4 Professor's Day, University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

10-12 Kentucky Academy of General Practice, Annual Scientific Assembly, Kentucky Hotel, Louisville

13-14 Kentucky Surgical Society Annual Meeting, French Lick Sheraton Hotel, French Lick, Indiana

18-19 Kentucky Pediatric Society Annual Meeting, Owensboro

IN SURROUNDING STATES

FEBRUARY

16-17 Current Concepts in Angiographic Diagnosis, Cleveland Clinic

21-23 American Academy of Allergy, Annual Meeting, Americana Hotel, New York City

28-Mar. 3 Southeastern Surgical Congress, Marriott Motor Hotel, Atlanta

MARCH

4-9 American Association of Pathologists and Bacteriologists, Statler-Hilton Hotel, Cleveland

7-10 New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans

9-10 Advances in Urology, Cleveland Clinic

16-17 Anesthesiology Postgraduate Course, Cleveland Clinic

21-Apr.2 "Laryngology and Bronchoesophagology" Postgraduate Course, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and U. of I. College of Medicine, at the Infirmary

23-24 Common, Neurological Problems, Cleveland Clinic

the price of "success"



Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

THERAPY
YOU CAN STAY
WITH

METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

MEDICAL SCHOOL NEWS

U. of L. Announces $170,869 In Med School Grants

The University of Louisville Board of Trustees, at its January 19 meeting, announced that $170,869 in gifts and grants had been accepted for various uses by the School of Medicine.

U.S. Public Health Service grants were awarded to the following:

William A. Brodsky, M.D., $42,000 for study of transport mechanisms for water and ions in the kidney tubulars. Truman Mays, M.D., $19,512, for the study of some of the blood chemicals in the state of delirium which frequently follows severe and multiple injuries. Pinghui V. Liu, M.D., $16,683 as a career-development award in microbiology. Ronald S. Wilson, M.D., $18,799, for studies in the nervous system, including certain reactions of the sympathetic nervous system.

Other gifts and grants were awarded to:

Billy Andrews, M.D., Duncan R. MacMillan, M.D., Leonard R. Reisman, M.D., and Kareem B. Minhas, M.D., $41,275 from the WHAS Crusade for Children for cardiology, endocrinology, the blood disease center, and the newborn care unit in the department of pediatrics.

William H. Anderson, M.D., $25,000 from Vick Laboratories to assist in his work involving evaluation of expectorants. Roderick Macdonald, M.D., $5,000 from Research to Prevent Blindness, Inc.

The Board also announced the approval of the following staff appointments: Victor P. Matibag as part-time instructor in neurology; Ronald L. Levine, M.D., as part-time instructor in obstetrics and gynecology; and Chauncey D. Leake, M.D. as distinguished visiting professor of pharmacology.

Student AMA

University of Kentucky College of Medicine

On November 18, the local SAMA chapter presented a panel discussion on "Moral Questions in Human Experimentation", open to the entire University and attended by more than 200 students and faculty members. Panelists were the chairmen of the departments of medicine, surgery, philosophy, and the dean of the Law School.

A series of films on medical topics have been scheduled throughout the year for medical students as supplements to normal classroom handling of the same topics.

Our Research Committee has developed a program to encourage independent laboratory and library research by the students during free summer and elective periods. Each winter the committee prepares a catalog of available research topics of current, active interest to instructors of every department.

The catalog explains procedures for applying to professors and to the various research foundations which supply $600 tax-exempt grants. Last year this catalog greatly increased student interest in summer research and facilitated the application process.

As a follow-up program, an award from SAMA for the outstanding research paper will be presented on Awards Day, which is scheduled for April of this year.

An active Curriculum Evaluation Committee began work last spring surveying and compiling student reaction to various aspects of the curriculum. Questionnaires on each course were distributed, the answers were tabulated, and the results reported to the respective department heads.

An SAMA chapter holds a Clinical-Pathological Conference contest each year for the student body. Awards are made to students with a high rate of correct diagnoses for the year.

Recently the SAMA chapter has undertaken to have representatives attend the meetings of the university pre-medical society, to offer advice to pre-med students in preparing for their medical training.

Entertainment functions for the year include a fall picnic honoring freshmen students, and a spring dance in honor of SAMA members and the faculty. At the dance the annual "Golden Apple Award" will be presented to the students' choice for outstanding preclinical instructor, and special recognition will be given to outstanding members of the house staff of the University Hospital.

Following is a list of officers of the University of Kentucky SAMA chapter; president, Phillip K. Blevins; vice-president, Martin A. Wheeler; secretary, James R. Harrod; and treasurer, Ray Jacobsen.

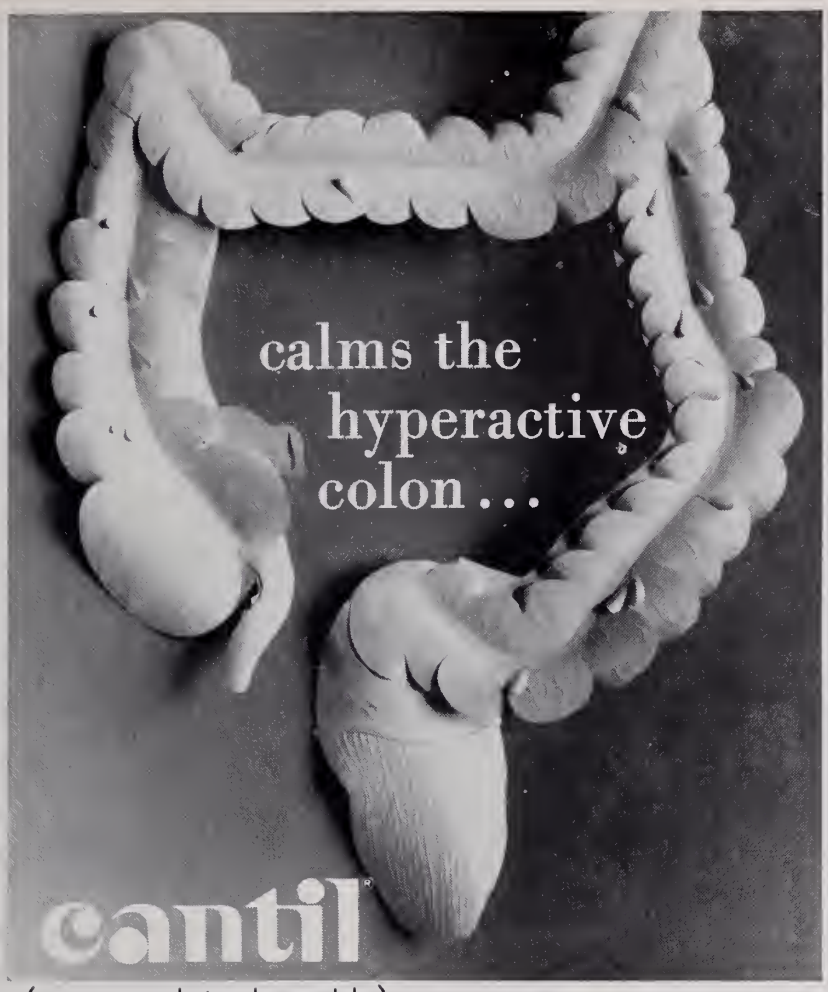
James R. Harrod, Secretary

Dr. Bost Gets Medicare Post

A recent announcement by the Bureau of Health Insurance, administrator of the U.S. government's medicare program, indicated that Howard L. Bost, M.D., Lexington, has been appointed deputy director of the program. Doctor Bost is assistant vice-president for program and policy planning at the University of Kentucky Medical Center.

WANTED—INTERNIST, Board Eligible or Certified. To be associated with twelve man specialty group; Salary open; No investment; Early partnership; Progressive city of 35,000 in central Texas.

Write J. D. Wilson, M.D.
King's Daughters Clinic
Temple, Texas



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

Digest of the Minutes of the Board of Trustees Meeting

December 8 and 9, 1965

FOLLOWING the opening of the meeting and the customary announcements, the Board turned its attention to a matter relating to one of the larger groups in the state that had been pending for a long time. Full consideration was given to information developed by an investigation and after full discussion. the Board voted to drop the matter.

Ellsworth C. Seeley, M.D., London, was elected to serve the last year of a three-year term of Robert E. Pennington, M.D., also of London, who had been elevated to the office of president-elect.

The Board then set the date for the 1971 Annual Meeting and disposed of miscellaneous matters.

Eugene H. Conner, M.D. was elected to the chairmanship of the KMA Memorials Commission replacing the late Carlisle Morse, M.D.

After hearing the request that the KMA publish a directory of KMA members giving phone numbers, office hours, and specialties, the Board voted to appoint a committee that would give this matter careful study and report back to the Board.

The KMA Board nominated three members for consideration of the Governor, as provided by the Statutes, to fill an appointment expiring December 31 on the State Board of Health. It then heard a report from Tom Wallace, M.D., director of the Louisville-Jefferson County Health Department, on an AMA-sponsored meeting covering venereal diseases.

Multiple recommendations from the KMA Council on Legislative Activities were considered and disposed of.

The KMA Delegates to the AMA reported on both the special meeting of the AMA House of Delegates on October 2 and 3 and the regular Interim Meeting, November 28-December 1.

It will be remembered that at the close of Reference Committee Report #3 during the last session of the House of Delegates, Wednesday, September 22, the House voted to refer the entire Reference Committee Report #3 to the Board of Trustees after being unable to agree on the interpretation of the issue of "participation". It was decided at that time that the Board of Trustees would be able to act on this matter after the special October 2 and 3 meeting of the AMA House of Delegates.

The Board of Trustees considered the actions of Reference Committee #3 and adopted the report as a whole (as amended by the House) and directed the General Counsel of the Association to present in the January 1966 Communicator (KMA Newsletter) the circumstances under which any KMA member might legally refuse to participate under PL 89-97. This was done in the January 1966 issue and additional copies of this statement are available on request.

The Special Ad Hoc Committee of the Board to Study PL 89-97 recommended that the Kentucky Blue Shield be designated as the carrier under PL 89-97, Title XVIII, Part B. The Board unanimously approved this request.

There was discussion relative to the joint meeting on medical education between the U. of L. and U. of K. faculties and representatives of the KMA January 22 and 23 at Park Mammoth Resort. It was agreed that approximately 15 from each one of the medical schools and 30 from KMA would constitute the representation at the conference.

At this point representatives of the State Board of Health who had previously been invited to the meeting appeared and matters of mutual interest were discussed.

The full minutes of this meeting are on file at the KMA Headquarters Office, and any member wishing to read them may do so.

Pertinent Paragraphs

The Drug Without Side Effects: "There exists an unrealistic public image of drugs that there could be remedial agents with various and optimum therapeutic effects without any toxicity. This is clearly utopian. The drug without side effects still remains to be discovered and it is most unlikely that it will ever be found." Cornielle J. F. Heymans, M.D., in *Georgetown Medical Bulletin,* (18:174-175), February 1965.

"Smart Pills"!: "Improved and more effective tranquilizers that do not produce drowsiness or other undesirable side effects will some day be available. Indeed, these future drugs affecting the nervous system and our moods will be aimed toward specific clinical indications. Some will be designed to aid in concentration, improve the memory, and also increase alertness during stressful periods and also assist slow learners and retarded persons. Others will remove grief and sadness, and some may be useful in alcoholism and other character disorders." Austin Smith, M.D., in *Emory University Quarterly,* (21:136-137), Summer 1965.

GENERAL PRACTICE: Central Kentucky. Unusual opportunity to join a large, active practice. Employee status leading to future partnership. Adequate office facilities, hospital privileges, substantial salary. Age to 40.

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a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

KMA Council and Committee Reports

Council on Communication and Public Service

N. Lewis Bosworth, M.D., Lexington, Chairman

KMA Headquarters Office **December 16, 1965**

The Council on Communications and Public Service held its first meeting of the associational year at KMA Headquarters and heard plans from the committee chairmen for the coming year.

Members of the council were briefed on the first KMA Orientation Program held during the 1965 Annual Meeting and were told that from all indications it was very successful. It was pointed out that 50 per cent of all new KMA members eligible to attend did so. It was further pointed out that the second Orientation Program would be held at the Interim Meeting at Cumberland Falls in April.

The Council gave approval to the selection of KMA exhibits for the annual meeting of KEA in April and the Kentucky State Fair in August. A general discussion was held on educational TV and it was the opinion of the council members that KMA should make use of ETV when it becomes fully operative in Kentucky. The next meeting of the council is scheduled for July 7 at which time the final report to the KMA House of Delegates will be prepared.

KMA Rural Health Committee

Donald L. Graves, M.D., Frenchburg, Chairman

KMA Headquarters Office **December 2, 1965**

The KMA Rural Health Committee reviewed the last Annual Rural Health Conference, held in Hopkinsville, on October 21, 1965.

A number of recommendations with regard to the 1966 Annual Rural Health Conference were made and will be submitted to the Kentucky Rural Health Council for its consideration.

Orientation Committee

N. Lewis Bosworth, M.D., Lexington, Chairman

KMA Headquarters Office **December 16, 1965**

The KMA Orientation Committee met recently at KMA Headquarters and reviewed the first Orientation Program for new members held during the Annual Meeting in September. It was felt that the program was very successful and that attendance was excellent. The committee planned the second Orientation Course which will be given at the KMA Interim Meeting at Cumberland Falls April 13 and voted to keep the same format as used for the first program.

Approval was given to the draft of the Orientation Booklet and Certificate to go to new members having completed the course. Members of the committee also noted that the KMA Bylaws were changed to the effect that "provisional status" no longer is to be used for the new member, but he is still required to attend an Orientation Course during his first two years of membership. *(Continued on Page 166)*

Founded in 1904

HIGHLAND HOSPITAL, INC.

ASHEVILLE, NORTH CAROLINA
Affiliated with Duke University





A non-profit, psychiatric institution, offering therapeuti milieu, group and individual psychotherapy, and standar somatic treatments. Limited day-patient and out-patient serv ices. The hospital is located in a 75-acre park amid th scenic beauties of the Smoky Mountain Range of Wester North Carolina, affording exceptional opportunity fo physical and emotional rehabilitation.

Contact: Medical Director, Highland Hospital, Asheville, N.C. 28801



approximating the diuretic efficacy of meralluride

METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

Blood Banks Committee

Ellis Fuller, M.D., Louisville, Chairman

KMA Headquarters Office **December 8, 1965**

Plans for a special edition of the KMA Journal highlighted the recent KMA Blood Bank Committee meeting. Members of the committee reviewed possible topics to be written, authors for each, and decided to have the special edition for early October 1966.

Considerable discussion was held on laws in the states of California, Michigan, and New Jersey pertaining to blood and blood banking activities. The committee members felt no medical legislation pertaining to rigid controls of blood banks is presently desirable in Kentucky but recommended that local county health societies be encouraged to help maintain proposed standards in the blood bank area.

The committee felt its future plans should center around functioning as a general source of information for the county societies; hence, concentrated attention on the special edition of the Journal.

KMA Technical Advisory Committee on Indigent Medical Care

C. C. Waldrop, M.D., Williamstown, Chairman

KMA Headquarters Office **November 23, 1965**

Suggested improvements in the Kentucky MAA and PAA Program were considered and recommended by the KMA Technical Advisory Committee on Indigent Medical Care.

A brief joint meeting with the Kentucky Pharmaceutical Association was held to discuss possible improvements which might be recommended to the Governor's Advisory Council on Medical Assistance with respect to the present prescription forms now in use under the program. These recommendations were presented to the Governor's Advisory Council on Medical Assistance at their meeting on December 8.

COUNTY SOCIETY REPORTS

McCracken

The regular meeting of the McCracken County Medical Society was held at Boswell's Restaurant in Paducah on December 15. No scientific program was scheduled, since election of officers for the coming year was to be held.

The financial report for 1965 was presented by the secretary-treasurer and was discussed by the membership, who approved the report.

There was a discussion of obtaining group insurance through Blue Cross-Blue Shield for the members of the Society. Following a lengthy discussion, the motion was made, seconded and carried to appoint a committee to investigate the insurance potential of the Society with particular attention to disability insurance, pension plans, and medical insurance. The committee will be appointed at a later date.

It was suggested and generally agreed upon that in future, dinner would be served at 6:30 on meeting nights so that meetings would not last into late evening.

A letter from Joseph R. Miller, M.D., Benton, trustee for the First KMA District, was read by the president. Doctor Miller requested that the McCracken County Medical Society host the First District at its meeting in January. Everett H. Baker, M.D., Louisville, KMA president, will speak. The motion was made, seconded, and carried, that the Society act as host.

Following the election of officers (see report below), the meeting was adjourned.

The following is a list of all County Medical Society officers recently reported to the Kentucky Medical Association Membership office. Reports received after the deadline for this issue will be published later.

Ballard

President, Glenn Baird, M.D., Bandana; vice-president, Sidney G. Dyer, M.D., LaCenter; secretary, J.M. Hunt, Jr., M.D., Wickliffe; delegate, Doctor Baird; alternate delegate, Doctor Hunt.

Boyd

President, Walter L. Cawood, M.D.; vice-president, Charles A. Webb, M.D.; secretary, Gerald B. Reams, M.D.; treasurer, Max E. Wheeler, M.D. Delegates to the AMA are: J.S. Wheeler, M.D., J.E. Stephenson, M.D., and John Ashworth, M.D. Alternate delegates: John Harrison, M.D., H.E. Martin, M.D., and W.R. Duff, M.D. All are from Ashland.

Bracken

President, James M. Stevenson, M.D., Brooksville; vice-president, Carl A. Marquardt, M.D., Augusta; secretary, D.E. Cummins, M.D., Brooksville. Doctor Stevenson will serve as delegate.

Bullitt

President, James W. Roney, M.D., Lebanon Junction; president-elect and secretary, Bruce Hamilton, M.D., Shepherdsville; delegate, Doctor Roney, and alternate delegate, John Gleason, M.D., Shepherdsville.

Carlisle

President, T.T. Brackin, M.D., Bardwell; secretary-treasurer, John T. O'Neill, M.D., Arlington. Doctor O'Neill will serve as delegate and Doctor Brackin as alternate.

Clinton

President, Earnest A. Barnes, M.D.; secretary, Floyd B. Hay, M.D.; delegate, Doctor Barnes; alternate delegate, Doctor Hay. Both are from Albany.

Elliott

President and secretary, Brown L. Adkins, M.D.; president-elect, John F. Greene, M.D.; delegate, Doctor Greene; alternate delegate, Doctor Adkins. Both are from Sandy Hook.

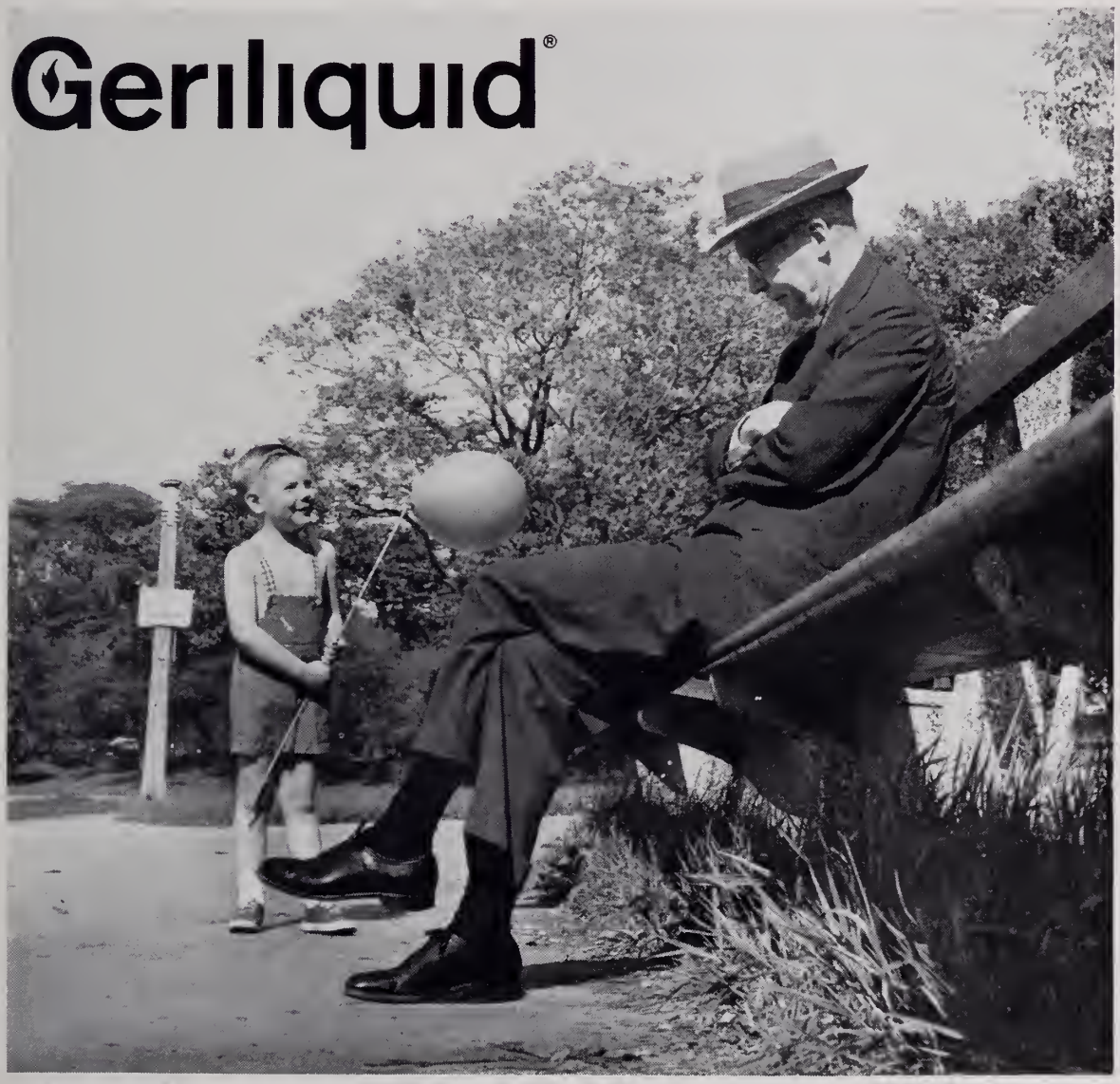
(Continued on Page 168)

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.
Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.
Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.
Supplied: Bottles of 8 oz. and 16 oz.

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Garrard

President, O.S. Playforth, M.D.; vice-president, George F. Berry, M.D.; secretary-treasurer, Paul J. Sides, M.D.; delegate, Paul E. Lett, M.D.; alternate delegate, Doctor Berry. All are from Lancaster.

Hardin-Larue

President, Carlos Hernandez, M.D.; vice-president, Thomas Ferriell, M.D.; secretary-treasurer, Ollie B. Emerine, M.D.; delegate, Fred C. Rainey, M.D.; alternate delegate, Willard Litzenberger, M.D. All are from Elizabethtown.

Hickman

President, C.J. Mills, M.D.; secretary-treasurer, H.E. Titsworth, M.D.; delegate, Doctor Mills; alternate delegate, Doctor Titsworth. Both are from Clinton.

Knox

President, H.L. Bushey, M.D.; secretary-treasurer, T.R. Davis, M.D.; delegate, Doctor Bushey, alternate delegate, W.P. Clifton, M.D. All are from Barbourville.

Laurel

President, Paul R. Smith, M.D.; vice-president, C.A. Wathen, M.D.; secretary-treasurer, Boyce Jones, M.D.; delegate, Doctor Smith; alternate delegate, Samuel M. Adams, M.D. All are from London.

Lincoln

President, H.I. Frisbie, M.D.; vice-president, T.J. Wright, M.D.; secretary-treasurer, Edward C. Bowling, M.D.; delegate, Doctor Bowling; alternate delegate, Doctor Wright. All are from Stanford.

McCracken

President, Walter Johnson, M.D.; vice-president, James Harris, M.D.; secretary-treasurer, Frank B. Crawford, Jr., M.D.; delegate, Winn Stryker, M.D.; alternate delegate, Charles Bohle, M.D. All are from Paducah.

McLean

President, Samuel Scott, M.D., Livermore; secretary, W. Gerald Edds, M.D., Calhoun; delegate, Doctor Scott; alternate delegate, Doctor Edds.

Perry

President, Mary Pauline Fox, M.D.; vice-president, Lyndon Combs, M.D.; secretary-treasurer, Charles C. Rutledge, M.D.; delegate, Doctor Fox. All are from Hazard.

Rockcastle

President, George H. Griffith, M.D.; vice-president, Jack Lewis, M.D.; secretary and delegate to KMA, Doctor Lewis. Both are from Mt. Vernon.

ACOG District V to Meet in Ky.

The Fifth District of the American College of Obstetricians and Gynecologists will meet in Louisville October 13-16. District V is composed of Kentucky, Indiana, Michigan, Ohio, and Ontario. Additional information will be published later in *The Journal*.

Psychiatric Patient at Work

(Continued From Page 132)

Summary

To briefly illustrate some of the problems and concerns of those of us involved with mental health of people at work, I have singled out one of the commonest prescriptions—time off for emotional disturbance. In examining this technique, I suggest it is incompatible with much of our contemporary thinking in psychiatry and should be used sparingly for illnesses which are not completely incapacitating. Rejection of an employee by the company at a time of such an emotional upheaval often may tend to reinforce the symptoms.

A necessary awareness on the part of the industrial medical consultant and, indeed, on the part of industrial management of personal factors influencing the employee were shown to be important. Contrary to many personnel management textbooks, one must have some awareness of the stressful factors impinging upon the life of an employee to intelligently alter his work situation without triggering the development of emotional difficulty. This suggests the value of more frequent use of the medical consultant at times of job change.

Finally, the clear demonstration of the value of appropriate medical care for the employee with the psychiatric problem brings home to each of us the tragically unsuccessful application of the "tranquilizer of the week" without more definitive psychological counseling.

WEAVERVILLE, TRINITY COUNTY, CALIFORNIA — Immediate opening for County Physician, Surgeon and Health Officer; Salary $12,000.00 to $18,000.00 negotiable. Modern 39-bed County-owned Hospital. Location 50 miles northwest of Redding. For further information contact Trinity County Board of Supervisors, Weaverville, California.

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

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NEWS ITEMS

Roy William Kirchberg, Jr., M.D., assistant instructor in pathology at the University of Louisville School of Medicine, is among the 91 recipients of senior clinical traineeship grants awarded by the U.S. Public Health Service for the study of cancer. The grants, totaling $971,500, will go to physicians who have completed residency training for an additional year's training.

William Watkins, M.D., Somerset, was notified recently of his certification by the American Board of Pediatrics. Doctor Watkins was graduated in 1960 from the University of Tennessee School of Medicine.

E. Fred Smock, M.D., Buechel, has announced the discontinuance of his private practice as of January 1, in order to enter a residency in radiology at St. Joseph Infirmary in Louisville.

John D. Ammon, M.D., is now associated with **H. L. Ravenscraft, M.D.,** at Hebron, where he will limit his practice to general medicine. Doctor Ammon was graduated in 1964 from the University of Louisville School of Medicine, and interned at Bethesda Hospital, Cincinnati, O. He is a native of Covington.

Victor Jenkins, M.D., is a new staff psychiatrist at Western State Hospital at Hopkinsville, it has been announced. Doctor Jenkins received his medical Degree from the University of Louisville School of Medicine in 1958, and took his residency training at Central State Hospital and Ypsilanti Hospital, Ypsilanti, Mich.

Okey H. Sanford, Jr., M.D., is now practicing in Ashland, where he is associated with Wayne Franz, M.D. A general practitioner, Doctor Sanford received his medical degree in 1963 from West Virginia University, and interned at Charleston Memorial Hospital. Before coming to Ashland, he was in practice at Montgomery, W. Va.

Harry L. Galloway, M.D., Paris, has opened an office in that city, where he will be in general practice. Doctor Galloway graduated in 1962 from Bowman Gray School of Medicine and interned at Greenville, S.C., before serving two years with the U.S. Public Health Service.

M. A. Greenwell, M.D., has started general practice at Elizabethtown, it has been announced. Doctor Greenwell, who received his medical degree from the University of Louisville in 1962, interned at St. Elizabeth Hospital in Dayton, O. He recently finished two years of service in the Air Force.

George H. Daaboul, M.D., has become associated with the Daniel Boone Clinic at Harlan, where he will limit his practice to internal medicine. Doctor Daaboul, a native of Lebanon, received his medical education at the University of Salamanca, Salamanca, Spain, and interned in Puerto Rico before coming to Harlan in 1962 for his residency training.

In Memoriam

WILLIAM MOORE HAMMACK, M.D.
Madisonville, Ky.
1879 - 1965

William M. Hammack, M.D., a general practitioner in Hopkins County for 58 years, died in Madisonville December 19 at the age of 86. A native of Webster County, Doctor Hammack attended the Ohio Valley College at Sturgis and received his medical degree from the Medical Department of the University of Louisville in 1905.

JOHN EDISON CRAWFORD, M.D.
Whitesburg, Ky.
1897 - 1965

John E. Crawford, M.D., 68, who had practiced medicine in Letcher County since 1929, died December 29 at a Whitesburg hospital. He had been in failing health for a number of years. Doctor Crawford graduated in 1927 from the University of Louisville School of Medicine, and practiced a year at Mt. Vernon before moving to Whitesburg.

CHARLES WILLIAM WHEELER, M.D.
Louisville, Ky.
1909 - 1966

Charles W. Wheeler, M.D., Louisville general practitioner, died Sunday, January 9 at a Louisville hospital as the result of injuries received the previous day in an automobile accident. He was a 1936 graduate of the University of Louisville School of Medicine.

Pertinent Paragraphs

"The samples you get from drug companies are intended for one purpose: to be given to patients as a trial. However, if no written prescription accompanies the sample, the transaction looks like the dispensing of a home remedy; or looks as if the patient is being used as a guinea pig. Common sense suggests that the sample should be accompanied by a written prescription for the same item." Editorial in the *Journal of the Medical Society of New Jersey*, (62:547), December 1965.

The Right to Prescribe—Right: "This gets down to the really basic controversy, where one exists, between physicians and welfare agencies on drug costs. We are willing, indeed we are anxious to prescribe economical drugs for our patients, whether on welfare or paying their own way — but it has to be the *right* drug. It is when we are denied the opportunity to provide for our patients the proper drug for their treatment, simply on a basis of cost, that we rebel." Burtis E. Montgomery, M.D., in *Illinois Medical Journal*, (128: 614), December 1965.



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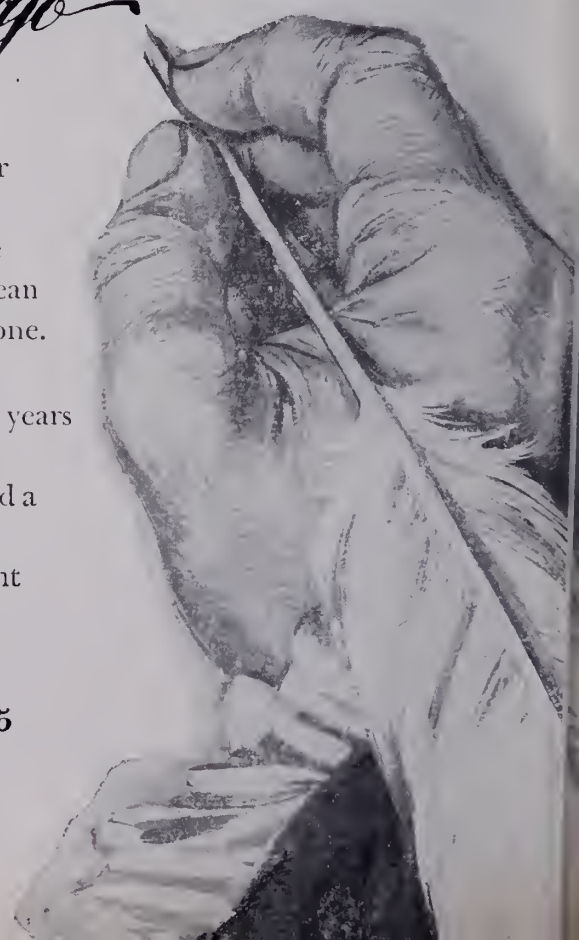
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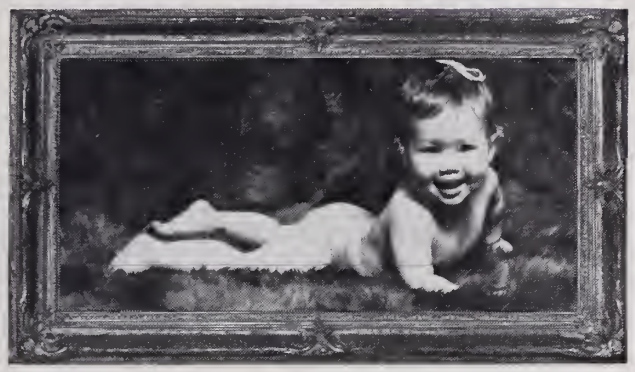


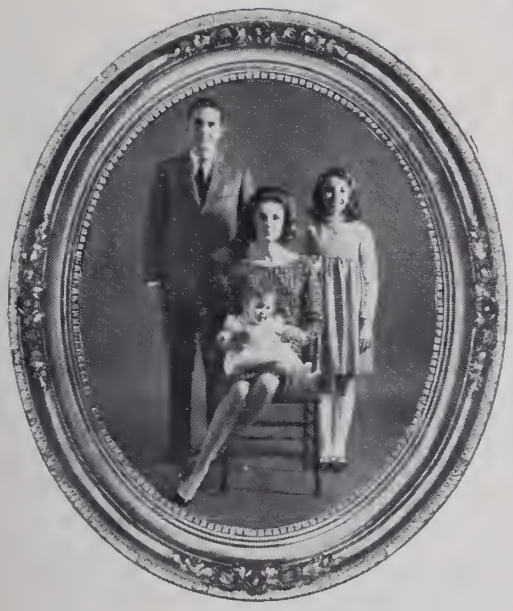
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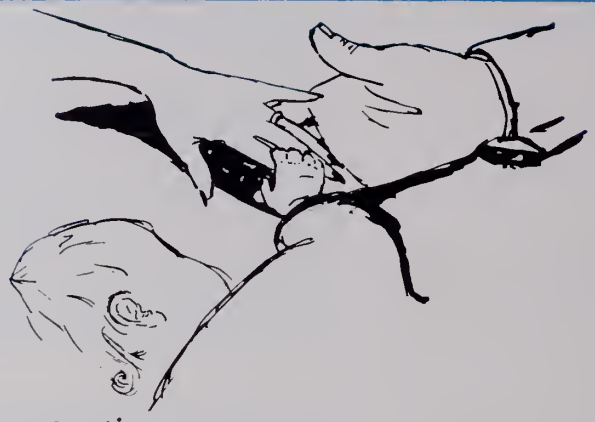
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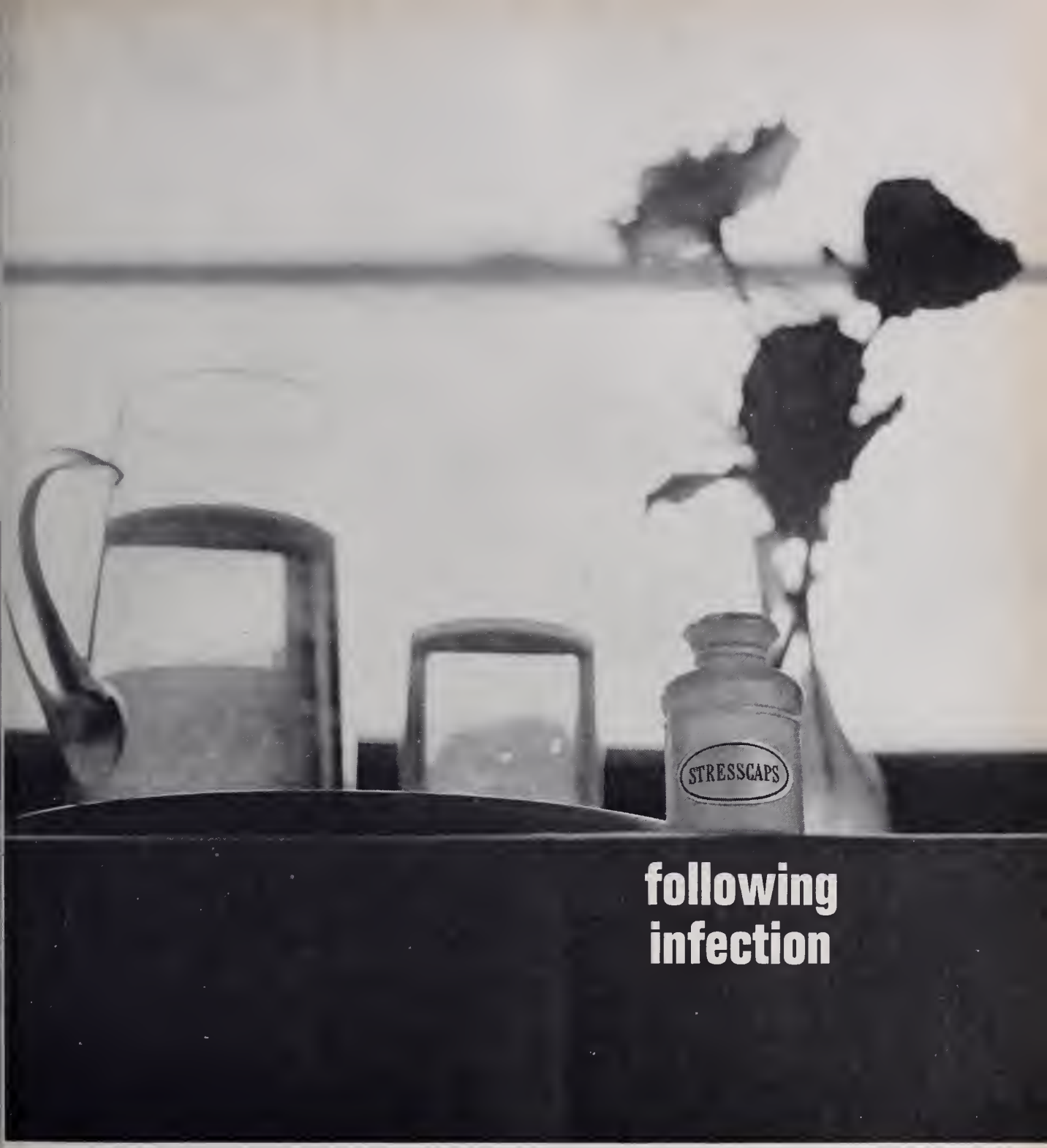
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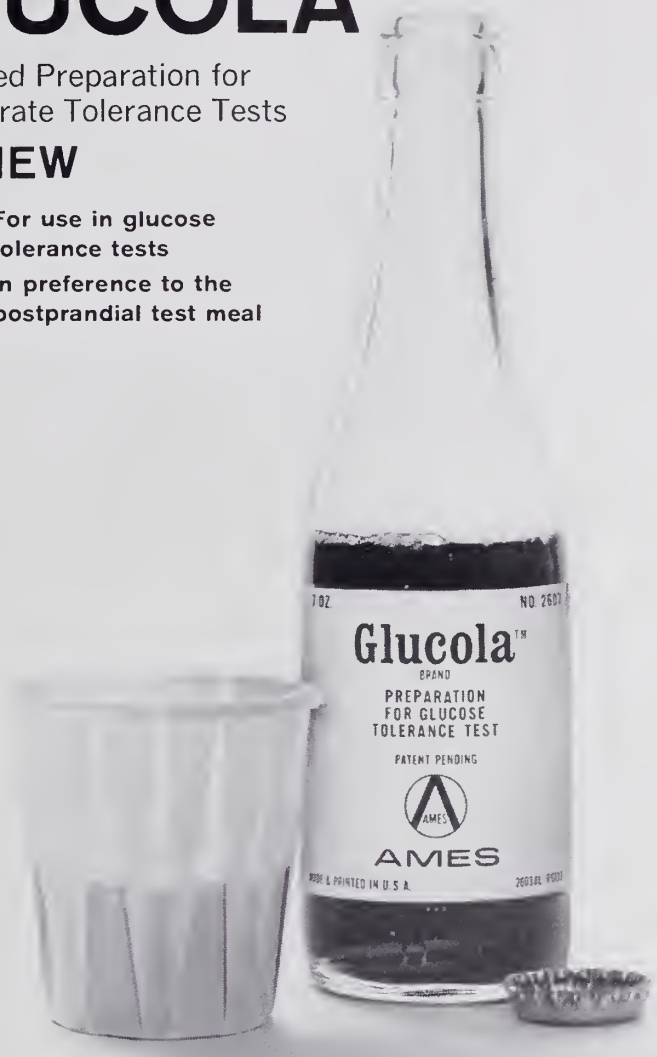
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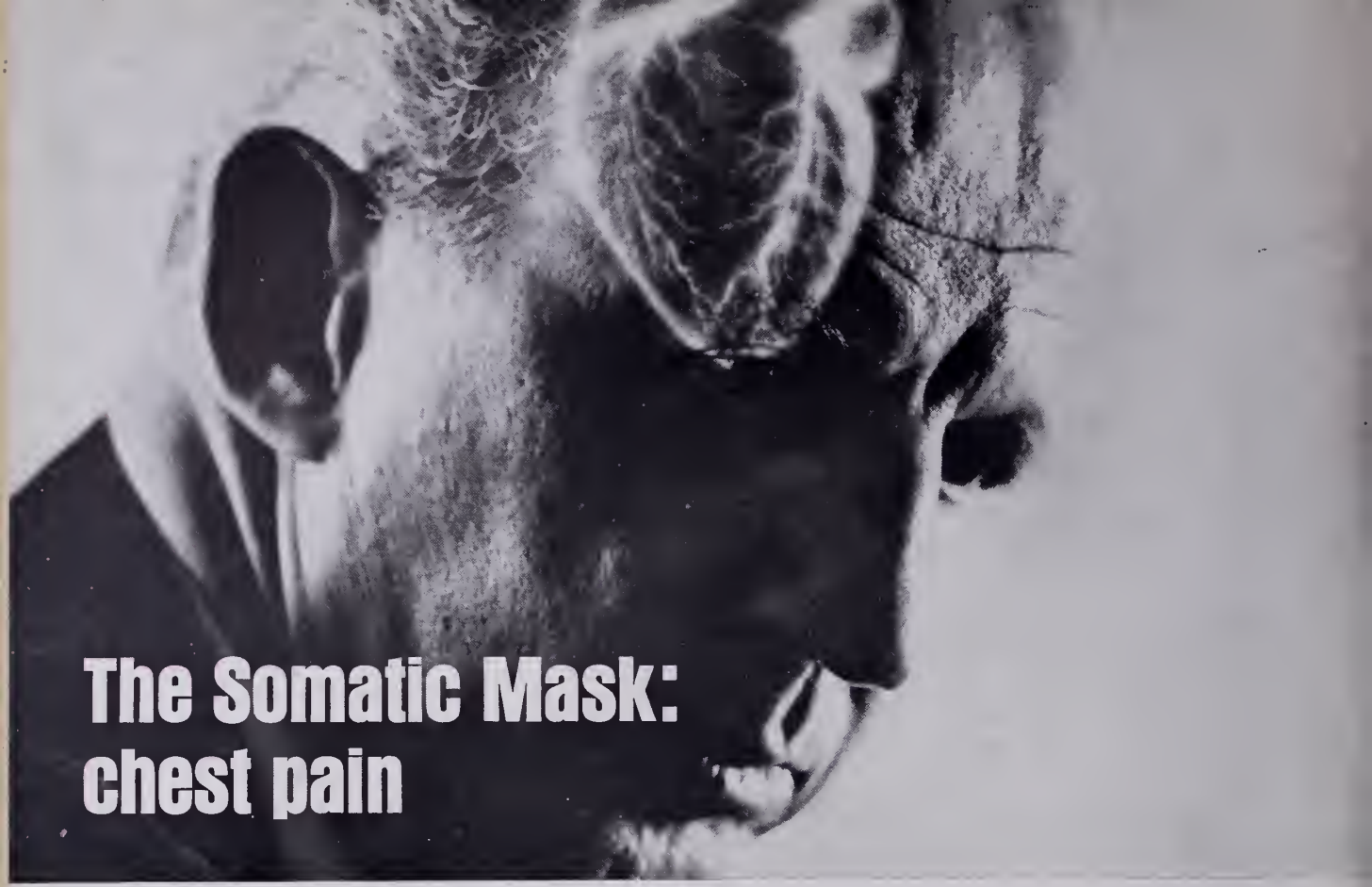
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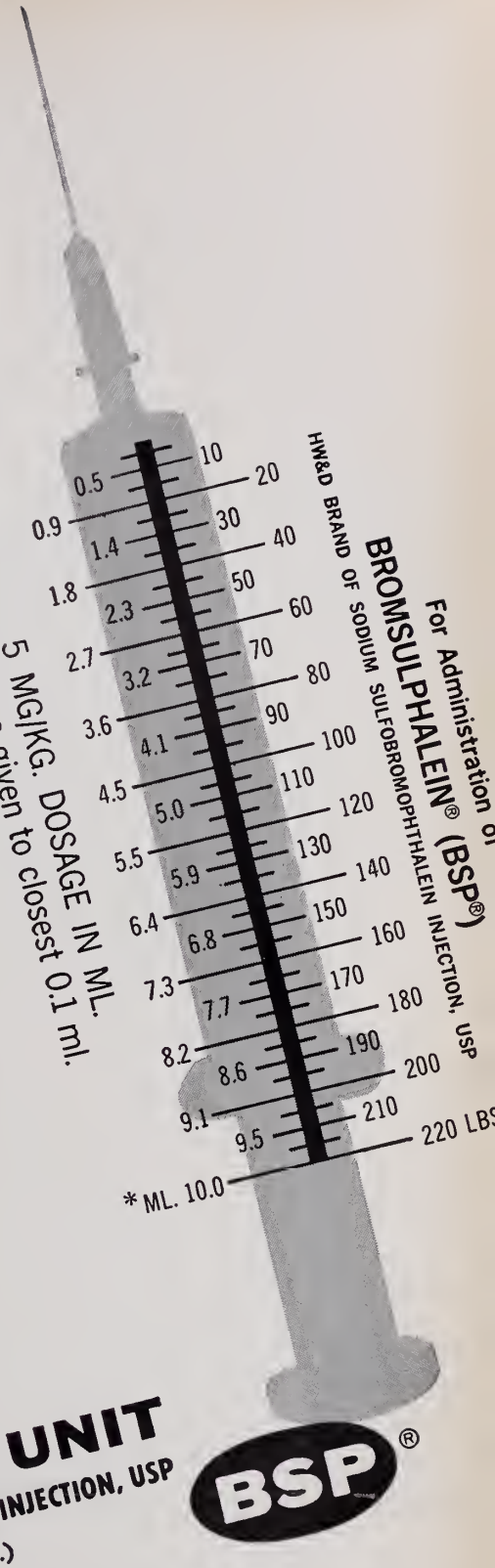
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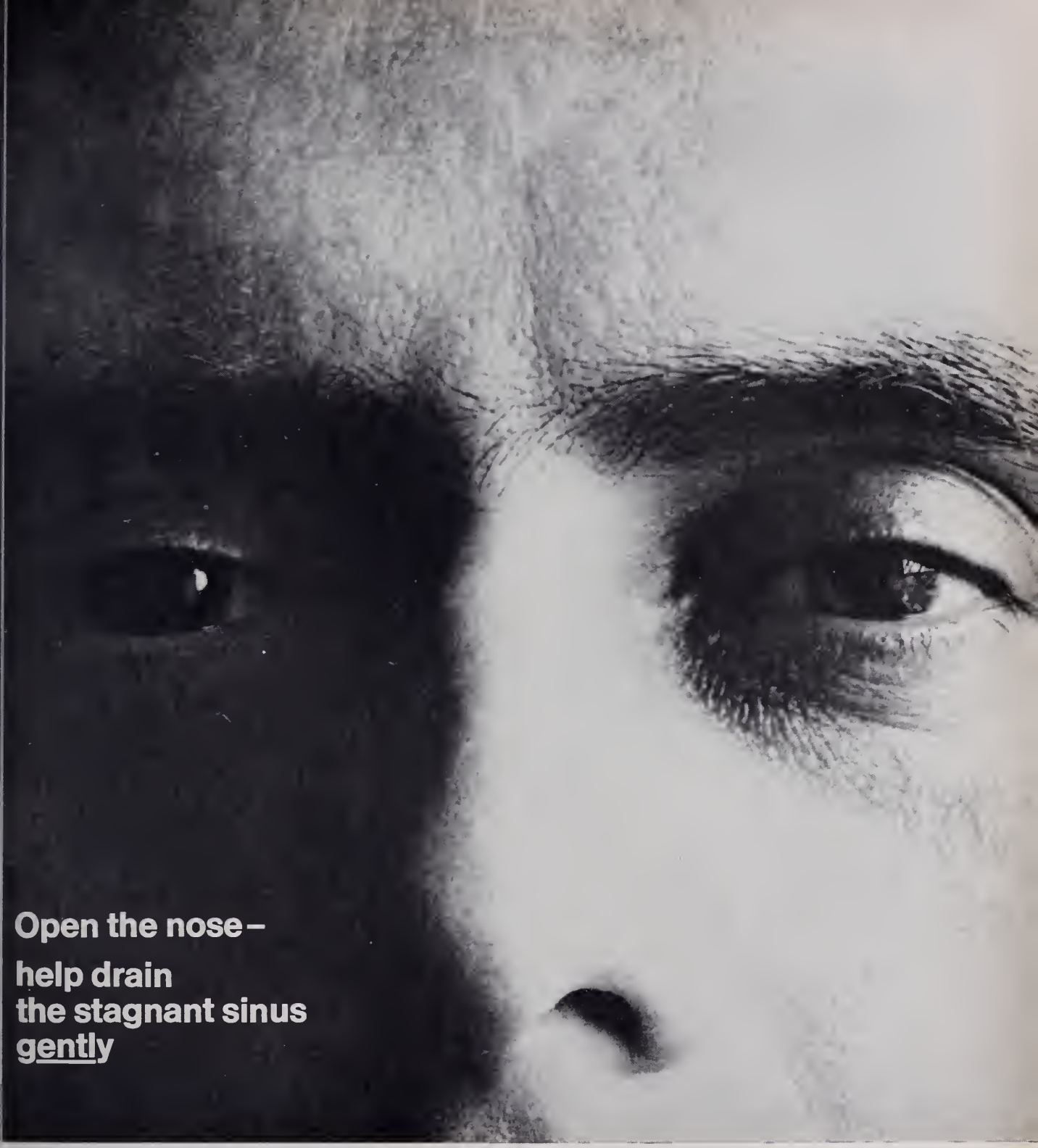
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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MESSAGE FROM THE PRESIDENT



Prevailing Fees — A Good Answer†

THROUGH the efforts of the physician members of the Kentucky Medical Association, our Blue Shield Plan was started in 1949. Allowances for professional services through the Blue Shield Certificates have been on an indemnity basis. The doctor made his usual charge to the patient and credited these allowances toward his charge.

In recent years the public, in some instances, has been requesting paid-in-full type benefits from the Blue Shield Plan. Major purchasers of health care want predictability of cost. To remain competitive and to render the best service possible to the people, Blue Shield has been required to develop a contract that will meet these demands.

The Prevailing Fees Program was developed to meet the demands of the purchasers of care and at the same time operate within established ethical principles.

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1. The fees are determined by physicians before the service is rendered and not afterward.
2. Individual physicians' fees may be adjusted by proper notification.
3. The program assures full payment for covered services regardless of specialty.
4. It allows consideration of fees higher than "usual" for complicated cases.
5. The program protects the doctor-patient relationship.
6. The medical profession's interest is protected by medical society guidance.

Let us all hope this progressive move by Blue Shield is a productive and successful venture.

GEORGE W. PEDIGO, JR., M.D.
VICE-PRESIDENT (CENTRAL)

†*This is the second in a series of guest articles written at the request of KMA president Everett H. Baker, M.D., by the president of the Woman's Auxiliary and the three KMA vice presidents.*



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Medicare Utilization Preview

ALL HOSPITALS participating in the medicare program will be required to have a utilization review program which meets conditions outlined by the Department of Health, Education and Welfare. These committees are to be functioning by July 1, 1966 when the program goes into effect. They will be organized under the hospital medical staff and composed of practicing staff doctors. If a hospital is too small, or the staff is not formally organized, the law provides that the utilization review committee may be organized by a local medical society or by a group of hospitals in the area.

The committees will have three separate and distinct but related functions:

1. *Medical care appraisal,* directed primarily to quality of professional care. To be accomplished by detailed study of case records following discharge of the patient.

2. *"Utilization Review":* review of case records with respect to efficient and appropriate use of hospital facilities and services. With this type of study, the committee attempts to identify patterns of inefficient or inappropriate hospital use and make correcting recommendations to the hospital administration or to the medical staff. While "utilization review" did not arise solely as an effort to combat rising costs, this factor admittedly is one of great importance.

3. *Claims Review:* This is the only committee function which has been spelled out in any detail in the regulations. Each "extended stay" case will be reviewed to determine if further hospital care is "medically necessary." If not, notification will be immediately sent to the attending physician, the patient and the hospital, and medicare payments will be stopped.

Quality of care appraisal and utilization study have long been strongly endorsed and encouraged by organized medicine. Hospital medical staffs have traditionally been charged with the responsibility for the quality of professional care rendered in the hospital, and in recent years has been added appraisal of whether use of hospital facilities was appropriate. These review programs have varied widely from hospital to hospital and in trying numerous approaches valuable experience has been gained in committee organization and function.

The claims review role, as outlined, departs significantly from the concept of utilization review advocated by the AMA and Joint Commission on Accreditation of Hospitals. It is primarily a policing function aimed at getting patients out of the hospital as quickly as possible. Claims review has in the past been a function of the county medical society, carried out on an after-the-fact basis, and almost uniformly at the instigations of third parties. The Department of Health, Education and Welfare would be wise to study further this aspect of the review plan and possibly provide for a variety of methods to accomplish the claims policing function. In this way an effective approach may be developed with a minimum of physician resistance.

WILLIAM W. HALL, M.D.

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: ACTIONS AND USES: A single dose of fmferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

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SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

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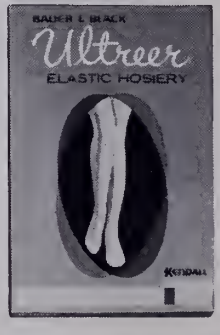
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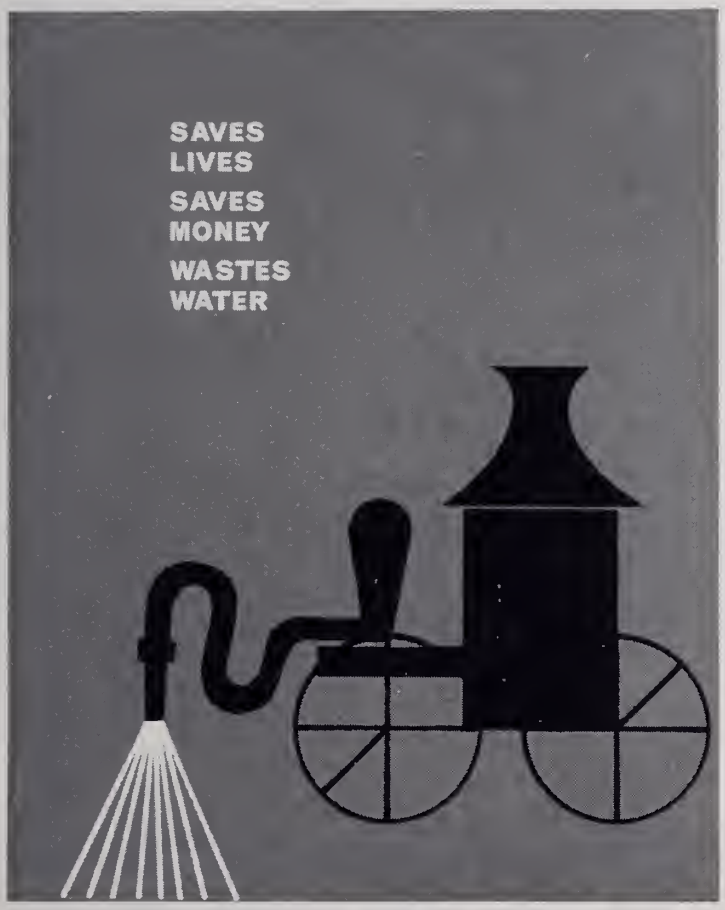


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Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

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ALEXANDER B. GUTMAN, M.D.: Professor of Medicine, Columbia University College of Physicians and Surgeons; Director, Department of Medicine, Mount Sinai Hospital, New York City.

RALPH A. JESSAR, M.D.: Assistant Professor of Medicine, University of Pennsylvania School of Medicine; Chief of Rheumatic Diseases Section of Graduate Hospital, University of Pennsylvania, Philadelphia, Pennsylvania.

DANIEL J. McCARTY, JR., M.D.: Associate Professor of Medicine and Head, Section of Rheumatology, Hahnemann Medical College and Hospital, Philadelphia; Editor, Arthritis and Rheumatism, Journal of the American Rheumatism Association.

MAX M. MONTGOMERY, M.D.: Professor of Medicine, University of Illinois College of Medicine; Attending Physician at the Research and Educational Hospital, Cook County Hospital and West Side Veterans Administration Hospital, Chicago, Illinois.

JOHN H. TALBOTT, M.D.: Editor, The Journal of the American Medical Association; formerly Professor of Medicine, University of Buffalo School of Medicine; Physician-in-Chief, Buffalo General Hospital, Buffalo, New York.

L. EMMERSON WARD, M.D.: Professor of Medicine, Mayo Foundation, University of Minnesota Graduate School; Consultant, Section of Medicine, Mayo Clinic, Rochester, Minnesota.

JOSEPH WARREN, M.D.: Associate Professor of Medicine, Director of Rehabilitation Service, University of Kentucky School of Medicine, Lexington, Kentucky.

U. OF L. FACULTY:

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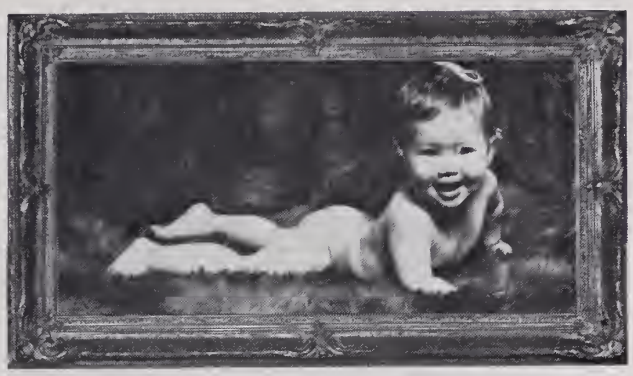
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GUEST SPEAKERS

WEDNESDAY, MARCH 30, 1966

"Diagnosis of Acquired Valvular Heart Disease"
NOBLE O. FOWLER, M.D., Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio

"Cineangiocardiography — Acquired Heart Disease"
F. MASON SONES, JR., M.D., Director of Cardiac Laboratory and Pediatric Cardiology, Cleveland Clinic Foundation, Cleveland, Ohio

"Pathogenesis of Rheumatic Carditis and its Significance"
BERNARD M. WAGNER, M.D., Professor and Chairman, Department of Pathology, New York Medical College, New York, New York

"Coronary Cineangiography"
F. MASON SONES, M.D.

"Current Concepts of Arteriosclerosis"
BERNARD M. WAGNER, M.D.

"Non-Rheumatic Myocardiopathies"
NOBLE O. FOWLER, M.D.

Panel: "The Big Heart"
RALPH M. DENHAM, M.D., Assistant Clinical Professor of Medicine, University of Louisville School of Medicine, Louisville, Kentucky — Moderator

THURSDAY, MARCH 31, 1966

"The Pitfalls of Surgery for Acquired Heart Disease"
HERBERT E. SLOAN, JR., M.D., Professor of Surgery, Department of Surgery (Thoracic), University of Michigan Medical Center, Ann Arbor, Michigan

THE BERNARD D. ROSENBLUM MEMORIAL LECTURE
"Subtle Findings in Congestive Heart Failure"
R. BRUCE LOGUE, M.D., Professor of Medicine, Emory University Medical School, Atlanta, Georgia

"Cardiac Arrhythmias — Active"
HENRY J. L. MARRIOTT, M.D., Director of Clinical Research, The Rogers Heart Foundation, St. Petersburg, Florida

Luncheon Speaker — R. BRUCE LOGUE, M.D.
"Susceptibility to Heart Attacks"

"Cardiac Arrhythmias — Passive"
HENRY J. L. MARRIOTT, M.D.

"Triumphs and Failures in the Treatment of Congenital Heart Disease or It is Better to Have Your Heart Fixed When You're Young"
HERBERT E. SLOAN, JR., M.D.

Panel - "Prognosis of Cardiac Lesions With and Without Surgery"
F. ALBERT OLASH, M.D., Assistant Clinical Professor of Medicine, University of Louisville School of Medicine, Louisville, Kentucky — Moderator

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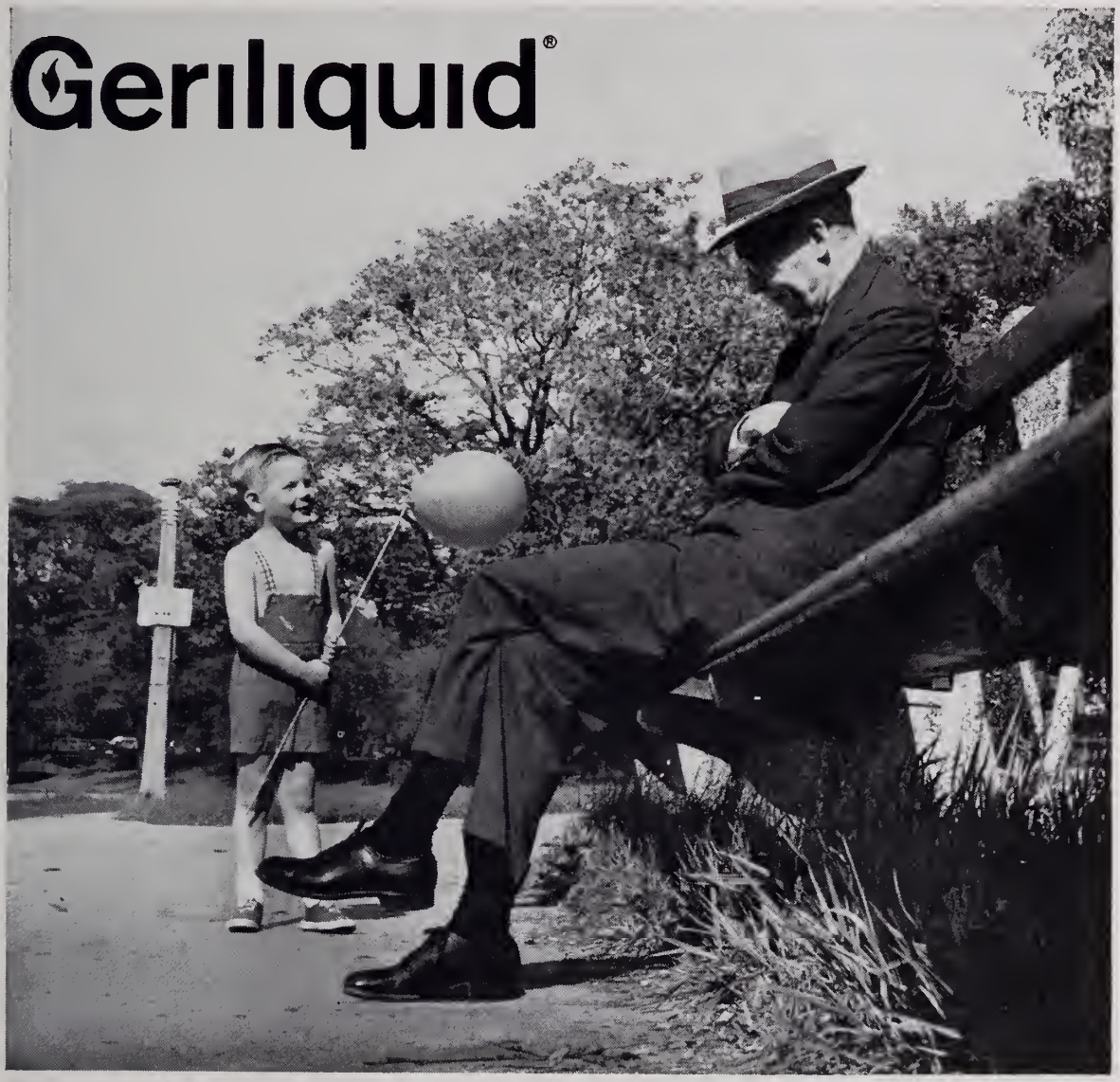
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PUBLIC HEALTH PAGE

Phenylketonuria†

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

WITH BETTER control of infectious diseases, metabolic and hereditary diseases have assumed increasing importance to doctors who are concerned with the care of children.

Phenylketonuria, or PKU, is an inborn error of metabolism which usually leads to severe mental retardation if untreated. When this disease was first discovered, it was thought to occur at a ratio of 1 to 20,000 people. It is now thought to occur at a ratio of 1 to 7,000 individuals.

In the 1950's a special diet became available for infants with this metabolic defect. It was then found that if the patients are treated early, within the first few weeks or months of life, mental retardation can usually be prevented.

In 1962 the Maternal and Child Health Division of the State Department of Health instituted a statewide urine screening program for PKU. This test is done when the baby is four to six weeks old. It depends upon the cooperation of each mother in submitting the required urine samples to the Chromotography Laboratory at Children's Hospital, Louisville, Ky.

New knowledge is being gained every year about PKU and other inborn errors of metabolism. An increasing number of similar diseases is gradually being discovered. Newer methods of detection and better methods for dietary control are constantly being improvised. With development of blood testing methods such as the Guthrie technique, PKU can now be detected when the baby is two to four days. This allows the testing of infants while they are still in the newborn nursery.

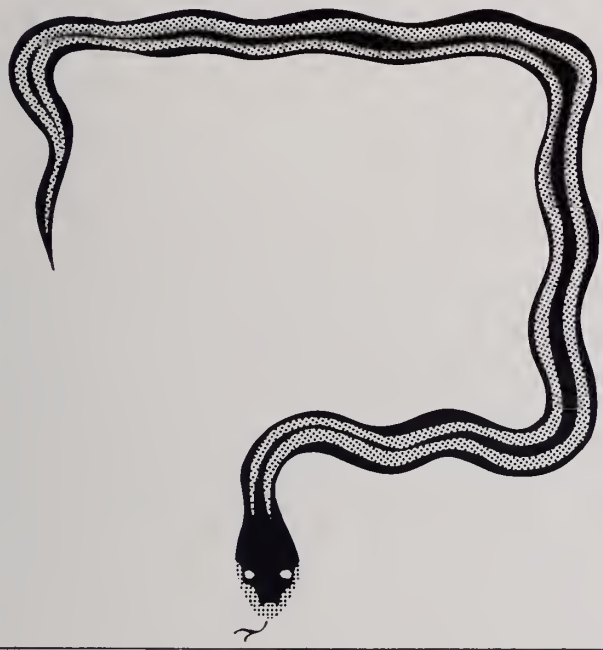
Several states have adopted legislation making the Guthrie testing of all newborn infants compulsory. Instead of taking such a step, it is felt that Kentucky should adopt a statewide voluntary PKU screening program for newborn infants. All hospitals in the state will be asked to submit blood samples on babies born in each hospital. This will enable earlier detection of PKU in affected infants. It will further allow for testing of a larger percentage of babies in Kentucky.

It is estimated that seven to ten new cases of PKU per year will be detected by this new method. Prevention of mental retardation in these children will be well worth the effort and expenditure for the screening program.

† This article was prepared by: Jo Anne Sexton, M.D., Director, Mental Retardation Program, Division of Maternal and Child Health, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky.

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Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide) —25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL —containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Signemycin 375—high-potency capsules for simpler administration, greater patient economy

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(tetracycline 250 mg. triacetyloleandomycin 125 mg.)

Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug. Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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Side Effects commonly associated with either component are possible but, to the extent these are dose-related, they should normally be mild and infrequent, since the total dosage of each component on the usual one-capsule-daily regimen is quite low. Also, the sedating effect of meprobamate and the stimulating effect of d-amphetamine sulfate tend, to some extent, to cancel each other out. Adverse effects not peculiar to either component have not been reported. Side effects associated with d-amphetamine sulfate include: insomnia, excitability, increased motor activity, confusion, anxiety, aggressiveness, increased libido, hallucinations, rebound fatigue, depression, dry mouth, anorexia, nausea, vomiting, diarrhea and increased cardiovascular reactivity. Effects associated with meprobamate include: skin rash, nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema, fever and transient leukopenia; also, very rarely, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, stomatitis, proctitis and anaphylaxis. Other serious effects have occurred after concomitant administration of meprobamate and other drugs. Massive overdosage may produce grave effects.

Precautions: BAMADEX SEQUELS should be given only under close supervision to patients hypersensitive to sympathomimetic drugs, with cardiovascular or coronary disease or who are severely hypertensive; to emotionally unstable persons and to epileptics. Patients should be cautioned not to drink alcoholic beverages while on the drug, and not to drive vehicles if they become drowsy. In all patients kept on the drug for long periods, the drug should be withdrawn gradually to avoid possible serious reactions.

Contraindications: Hyperexcitability, agitated prepsychotic states and a history of previous reactions to meprobamate.

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IN THE BOOKS

BONE TUMORS; Third Edition: by Louis Lichtenstein, M.D.; Published by The C. V. Mosby Company, St. Louis, 1965; 411 Pages; Price, $16.75.

This third edition has not been changed in form from the last edition published in 1959.

However, many chapters have been partially or entirely rewritten. A new chapter on benign and malignant chondroid tumors has been added. Also, many roentgenographic and photo-micrographic illustrations have been added and replace some of the old ones from the previous edition.

Both the roentgenograms and photo-micrograms are of excellent quality. The author thoroughly covers not only the microscopic findings of the various bone tumors, but also the clinical features (such as age, sex incidence, and localization), clinical history, roentgenographic appearance, treatment, and prognosis.

The book is well written and easy to read.

The price is very reasonable for such a comprehensive book, and certainly it will be very informative to the pathologist, orthopaedic surgeon, radiologist, or anyone interested in or dealing with bone tumors.

STANLEY W. COLLIS, M.D.

TRANSACTIONS OF THE NEW ORLEANS ACADEMY OF OPHTHALMOLOGY — SYMPOSIUM ON CATARACTS: Published by the C.V. Mosby Company, St. Louis, 1965; 319 Pages; Price, $19.50.

A symposium is one of the best known methods of imparting knowledge and that reported in this book, as are those published in earlier Transactions of the New Orleans Academy of Ophthalmology, is an excellent compilation. It should be studied carefully by all ophthalmologists and particularly by ophthalmic residents. The seven contributors are leading teachers and investigators as well as skillful surgeons. Each has presented his contribution to the symposium clearly, capably, concisely and in sufficient detail to give the meat of the matter. One can find points for minor difference of opinion in only a few instances.

Twenty-one chapters cover adequately the diagnosis and classification of cataracts; principles and techniques of surgery; the causes, prevention, treatment and pathology of complications which plague all cataract surgeons; the management of the aphakic patient, to help him make the difficult, delayed and discouraging adjustment to a vastly different kind of visual function from that which he enjoyed before cataracts developed.

One chapter, "High Magnification in Surgery of Cataracts", fascinatingly describes this comparatively recent method of doing ocular surgery with the aid of an operating microscope, similar to that which made end-aural surgery in otology so effective. Improving design of microscopes and techniques of microsurgery are steadily overcoming its disadvantages. It is being taught in more and more training centers and the next generation of ophthalmic surgeons should be skilled in its use.

Considerable space is given to the round table discussion, always popular with the audience in any symposium. Many questions, of wide variety, were submitted and the reader will glean numerous pearls of wisdom and experience from a study of this section.

In the preface of this book is the statement: "Cataract surgery remains the most dramatic and most successful accomplishment of the ophthalmic surgeon, but only because of the ceaseless quest to improve this fine record." The contributors to this symposium have pointed the way to still further improvement.

C. DWIGHT TOWNES, M.D.

THERAPEUTIC RADIOLOGY, RATIONALE, TECHNIQUE, RESULTS, Second Edition: by William T. Moss, M.D.; Published by the C.V. Mosby Company, St. Louis, 1965; 503 Pages; Price, $18.75.

This is a well conceived, well organized, well written book which should lead to improved patient care in the field of radiotherapy.

An initial chapter properly defines the specialty of radiotherapy and succinctly places in proper perspective its relationships with pathology, surgery, internal medicine and physics. Proper attention is given to the fundamental radiobiological concepts in radiotherapy. A chapter has been added on combinations of radiotherapy and surgery.

Following this are chapters on individual organ systems, each of which begins with the effect of irradiation on the normal tissue or organ involved and proceeds with a discussion of the rationale, technique and results of treatment of cancer of these individual organs. Proper attention is given to complications. Knowledge of physics is assumed.

This is not an encylopedia of oncology or radiotherapy, but should be of invaluable aid to the resident training in this field and a welcome addition to the library of his preceptors. Pathologists, sur-

geons, otolaryngologists, and gynecologists should also find it of value.

RALPH M. SCOTT, M.D.

THE DOCTOR AS A WITNESS: by John W. Tracy; revised by William J. Curran; Published by The W. B. Saunders Company, Philadelphia and London, 1965; 196 pages; Price $5.75.

"The interest in preparing this volume arises out of a conviction that those persons who work in a medico-legal field must endeavor to achieve better, more sympathetic, communication between the professions of medicine and law." "John W. Tracy wrote a very successful first edition of this book." The second edition has been written, revised, and re-edited by William J. Curran.

Chapters One and Two should be read by every physician in order to familiarize himself as to his actual responsibilities and duties as a witness and in his preparation for trial in case he is to be a witness. Chapter Three follows in logical sequence to concisely present what makes a good medical witness.

There are some questions that arise in the reviewer's mind as to the privileges and obligations of a doctor witness. These probably are best explained by your lawyer if you are called as a medical witness.

The remainder of the book is valuable information for the doctor who appears occasionally in court as a witness whether it be medical or not. This book should be in every physician's library and should be read by him before going to court.

CECIL W. SHAFER, M.D.

DIAGNOSIS AND THERAPY OF THE GLAUCOMAS, Second Edition: by Bernard Becker, M.D., and Robert Shaffer, M.D.; Published by the C.V. Mosby Company, 1965; 443 Pages; Price, $18.50.

This second edition of "Diagnosis and Therapy of the Glaucomas" is uniformly excellent, fascinating and informative. The changes over the past four years in thoughts, concepts, and frustrations in glaucoma management have been updated. It can be recommended to the busy ophthalmologist as a useful source of basic and clinical information.

In simple, straightforward style, the authors convey the current thinking on the pathogenesis, diagnosis, and management of the glaucomas. Methods of gonioscopy, tonometry, tonography, ophthalmoscopy and perimetry are discussed in detail and their clinical interpretations and applications are made clear through diagrams and tables.

The chapter on primary open-angle glaucoma has been enlarged to include the recent work on the genetic basis of glaucoma as revealed by the topical corticosteroid response.

The addition of goniophotographs taken from the "Steroscopic Manual of Gonioscopy" will be of particular help to clinicians in their evaluation of the anterior chamber angle.

This book is a significant contribution to the literature and will be welcomed by the specialist as well as the beginning ophthalmologist.

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

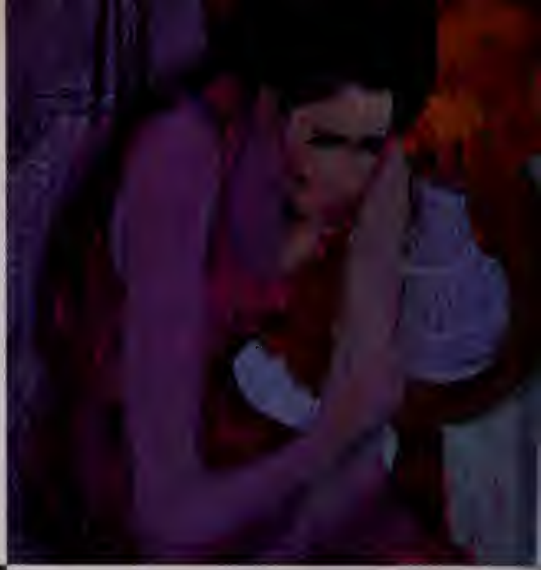
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chronic fatigue—lethargy



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when emotionally based complaints fit the symptom profile of depression



severe anorexia—weight loss

recurrent G.I. upset

Clinical Considerations: **Contraindications**—Glaucoma, urinary retention, bone marrow depression, pregnancy, drug-induced CNS depression. **Precautions**—The sam
those for the two components, perphenazine and amitriptyline. Use carefully in patients with histories of convulsive disorders or adverse reactions to phenothiazines. ETRA
potentiates effects of antidepressants, CNS depressants, atropine, phosphorous insecticides, and heat. The antiemetic effect of the perphenazine component may con
existence of brain tumor, intestinal obstruction, or toxicity due to overdosage of other drugs. Consider the possibility of potentiation in combined use with MAOI drugs. G
erally allow two weeks between therapies. Not recommended for use in children. **Warning:** Patients who become drowsy with ETRAFON should be cautioned against drivin
car or operating machines requiring alert attention. Response to alcohol may be potentiated. **Side Effects**—Similar to those reported following the use of either compon
when used alone. For perphenazine alone, side effects caused by any of the phenothiazines may occur. These include extrapyramidal symptoms, autonomic reacti
(including hypertension), blood dyscrasias, liver damage, endocrine disturbances, allergic reactions, peripheral and cerebral edema, reversed epinephrine effect, grand
convulsions, polyphagia, reactivation of psychotic processes. For amitriptyline alone, drowsiness, hypotension, numbness and tingling of extremities, transient confusion
high dosages), activation of latent schizophrenia (although perphenazine in ETRAFON may prevent this reaction in some cases). Dose-related anticholinergic reactions are
sible. Rare appearance of agranulocytosis, jaundice, and peripheral neuropathy, all possibly of drug origin, have been reported in patients receiving amitriptyline. For n
complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07
(1) Lehmann, H. E.: Psychosomatics *6*:266, 1965. (2) Splitter; S. R.: Psychosomatics *6*:322, 1965. (3) Smith e Incas, J.: Internat. J. Neuropsychiat. *1*:220, 1965. (4) Coffee, H
J. M. A. Georgia *53*:107, 1964. (5) Bowes, H. A.: Psychosomatics *5*:44, 1964. (6) Pennington, V. M.: Combined Psychopharmacological Treatment of Depression, Scien
Exhibit, 18th A.M.A. Clinical Convention, Miami Beach, Nov. 29-Dec. 2, 1964. (7) Dorfman, W.: Psychosomatics *5*:7, 1964. (8) Mattey, W. E.: Current Therap. Res. *5*:310, 1

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When the patient's symptom pattern and the absence of physical findings confirm your suspicion of a depressive state, ETRAFON will usually reverse the mental and functional slowdown—and allay the anxiety that accompanies depression. *"...it is rare to find a depressed patient who does not also present definite symptoms of anxiety."*[1]

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Low incidence of side effects: Mattey[8] reports that with ETRAFON "Side effects are relatively few...." Another investigator[2] states that side effects with amitriptyline-perphenazine combination are less than with each component alone. In Pennington's study of 428 patients, side reactions were less than half as frequent with ETRAFON as with perphenazine alone, toxicity was low, and the absence of extrapyramidal symptoms was regarded as "... particularly noteworthy."[6]

*ETRAFON offers the flexibility and convenience of 2 additional dosage strengths: (1) For more severe cases with predominant anxiety—*ETRAFON-FORTE *(amitriptyline HCl 25 mg. and perphenazine 4 mg.); (2) for adolescent or geriatric patients—*ETRAFON-A *(amitriptyline HCl 10 mg. and perphenazine 4 mg.).* S-915

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brand of antidepressant-tranquilizer

amitriptyline hydrochloride 25 mg. and perphenazine 2 mg.



the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

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IN KENTUCKY

MARCH

21 KMA Senior Day, University of Louisville School of Medicine, Rankin Amphitheater

24-26 Fourth Annual Seminar of Department of Pediatrics, University of Kentucky Medical Center

28 Governor's Conference on Occupational Health, Brown Hotel, Louisville

30-31 Heart Association of Louisville and Jefferson County 12th Annual Symposium on Cardiovascular Disease, Brown Hotel, Louisville.

31 11th Annual Lexington Clinic Conference, Lexington; 8:30 a.m.

APRIL

4 Louisville-Jefferson County Obstetrical and Gynecological Society meeting, Executive Inn, Louisville

5 KMA Thirteenth Trustee District Meeting, Ashland

5-8 Kentucky Dental Association Annual Meeting, Louisville

6 Professor's Day University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

7 KMA Eighth Trustee District Meeting, Covington

8-10 Ky. Chapter, American College of Surgeons, Lexington

12 KMA Senior Day, University of Kentucky Medical Center, Lexington

13-14 KENTUCKY MEDICAL ASSOCIATION Interim Meeting, Cumberland Falls

14-16 Kentucky OB-GYN Society Annual Meeting; Netherland Hilton Hotel, Cincinnati

18 KMA Fifth Trustee District Meeting, Medical Arts Building, Louisville

21 Kentucky Thoracic Society Annual Meeting, in conjunction with Kentucky TB & RD Association Meeting, Rankin Amphitheater, Louisville General Hospital

25-28 Kentucky Hospital Association Annual Meeting, Louisville

28 Ky. Chapter, Arthritis Foundation, Symposium on Rheumatic Disease, Co-sponsored by U. of L. School of Medicine. At Rankin Amphitheater, Louisville General Hospital

MAY

2-6 Symposium on Cardiovascular Disease, University of Kentucky Medical Center

4 Professor's Day, University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.

11-13 Kentucky Academy of General Practice, Annual Scientific Assembly, Kentucky Hotel, Louisville

13-14 Kentucky Surgical Society Annual Meeting, French Lick Sheraton Hotel, French Lick, Indiana

18-19 Kentucky Pediatric Society and Kentucky Chapter, American Academy of Pediatrics, joint annual meeting, Owensboro

IN SURROUNDING STATES

MARCH

16-17 Anesthesiology Postgraduate Course, Cleveland Clinic

21-Apr. 2 "Laryngology and Bronchoesophagology" Postgraduate Course, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and U. of I. College of Medicine, at the Infirmary

23-24 Common, Neurological Problems, Cleveland Clinic

23-25 American Surgical Association, Boca Raton Hotel, Boca Raton, Fla.

30-31 Medical Progress and its relationship to Dentistry, Cleveland Clinic

APRIL

4-8 Workshop in Teratology, sponsored by AMA, Teratology Society, and University of Colorado; at Boulder, Colo.

6-7 Current Management of Orthopedic and Traumatic Problems, Cleveland Clinic

11 Workshop in Radioisotope Scanning, Emory University Department of Radiology; at Emory University, Atlanta

14-19 American Dermatological Association; at Hot Springs, Va.

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When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials—usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

Indications: Diarrhea. *Contraindications:* Kaolin Withhold if diverticulosis is present or suspected *Precautions:* Sulfonamide: Continued use require supplementary administration of thiamine and vita

your Rx for Cremomycin can provide relief



min K. Neomycin: Patient should be observed for new infections due to bacteria or fungi. *Side Effects:* Sulfonamide: Sensitivity reactions may occur (e.g., skin rashes, anemia, polyneuritis, fever; agranulocytosis with a fatal outcome has been reported). Reduction of thiamine output in the feces and of vitamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.

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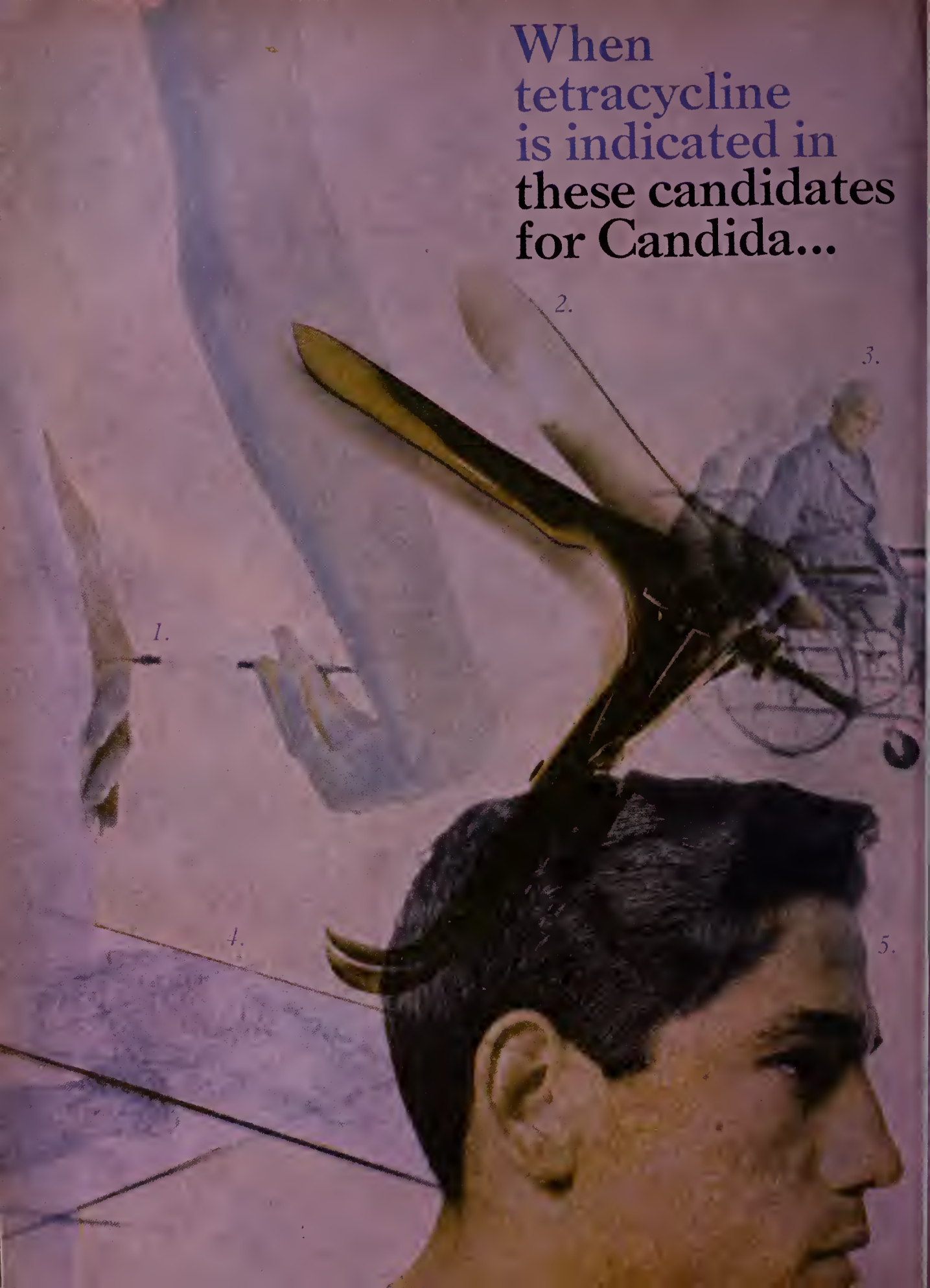
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Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

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When
tetracycline
is indicated in
these candidates
for Candida...
1.
2.
3.
4.
5.

New low-cost tetracycline/ antifungal therapy

Tetrex®-F

tetracycline phosphate complex –nystatin

Because new Tetrex-F (tetracycline phosphate complex-nystatin) is the most economical therapy of its kind that you can prescribe, it is a sound choice whenever tetracycline therapy is indicated in patients predisposed to monilial infections.

Who are these "candidates for Candida"?

1. diabetic patients
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3. elderly or debilitated patients
4. patients with a past history of moniliasis
5. patients on long-term tetracycline or corticosteroid therapy.

For these patients, Tetrex-F (tetracycline phosphate complex-nystatin) provides efficient tetracycline therapy against a broad range of infections *plus* protection against superinfection associated with the overgrowth of *C. albicans* in the G.I. tract.

Priced for savings

Tetrex-F (tetracycline phosphate complex-nystatin) is lowest in cost—priced 20% lower than most tetracycline/antifungal products.

BRISTOL THERAPEUTIC SUMMARY

For complete information consult Official Package Circular.

Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.

Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dosage: 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.

Supply: Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. Oral Suspension, 60-ml. bottle. Each 5 ml. contains tetracycline equivalent to 125 mg. tetracycline hydrochloride and nystatin, 125,000 units.

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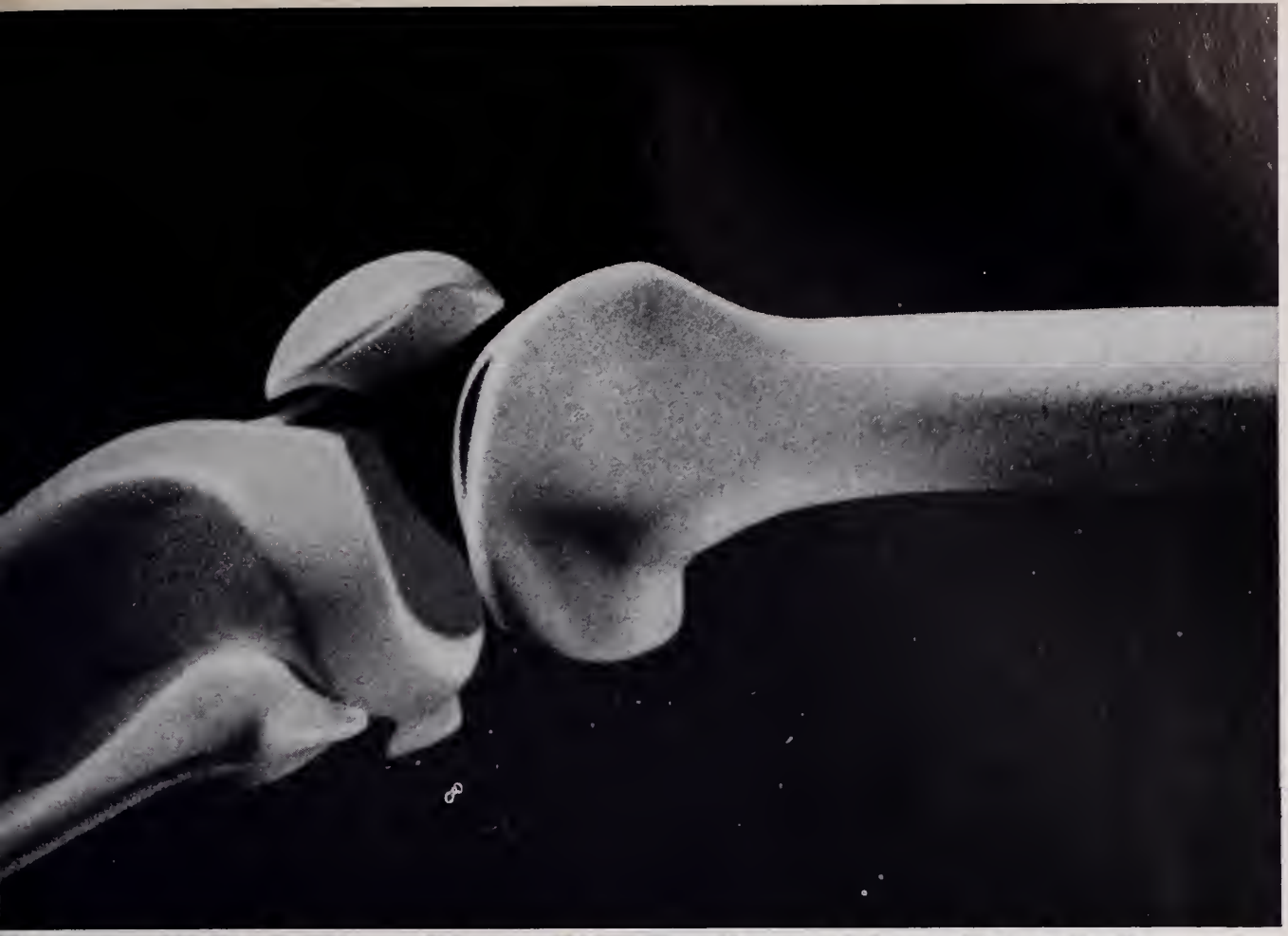
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recautions
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The Diagnosis and Therapy of Hemorrhagic Disorders Occurring During Surgery

William S. Howland, M.D.*
New York, N.Y.

Bleeding during surgical operations is usually due to thrombocytopenia, a deficiency of plasma clotting factors or fibrinolysis. This defect may be diagnosed by bleeding time, clotting time, prothrombin time, clot retraction and whole clot lysis.

BLEEDING is a normal accompaniment of surgical procedures. Often this bleeding becomes abnormal due to a defect in the hemostatic mechanism. Since at the present time it is impossible to routinely screen all surgical patients with extensive clotting profiles, the recognition of these defects when they occur is extremely important. Unfortunately clotting defects often happen when the clotting laboratories are not in operation. It thus becomes imperative that the clinician in the operating room understands the mechanisms of hemostastis, the defects that can occur, and the therapy indicated.

Hemostatic Mechanism

Hemostasis involves an interdependence of the blood platelets, the coagulation mechanism and the blood vessels. The least understood and the least studied factor in hemostasis is that involving the blood vessels. Since at the present time the contributions of the vascular factor and platelets to hemostasis cannot be clearly separated they will be considered together.

Following puncture or cutting of blood vessels, platelets accumulate at the site of injury with extreme rapidity and adhesion of the platelets to the damaged area begins at once. The platelets adhere not to the injured cells but rather to the intercellular junctions and to areas denuded of endothelial cells. This aggregation of platelets at the site of injury forms a temporary plug which in small arteries and veins is capable of effectively arresting bleeding. Simultaneous with the formation of the platelet plug, vasoconstriction of muscle containing vessels also takes place. This is a reflex response and is inadequate to produce hemostasis.

Platelet plugs are at first fragile and permeable to the blood, with fragments constantly being dislodged by the stream of flowing blood. New platelets are continually added and the plug gradually develops greater resistance and tensile strength. The conversion of the friable plug into an effective hemostatic structure depends largely upon platelet retraction, a process accomplished by action of platelet contractile protein, triggered by thrombin and other platelet agglutinating factors. This process of platelet aggregation and fusion has been termed viscous metamorphosis. At the point when platelet fusion occurs, a second type of vasoconstriction takes place, affecting not only the injured vessel but neigh-

† *Presented at the First General Scientific Session of the Kentucky Medical Association Annual Meeting in Louisville, September 21-23, 1965.*
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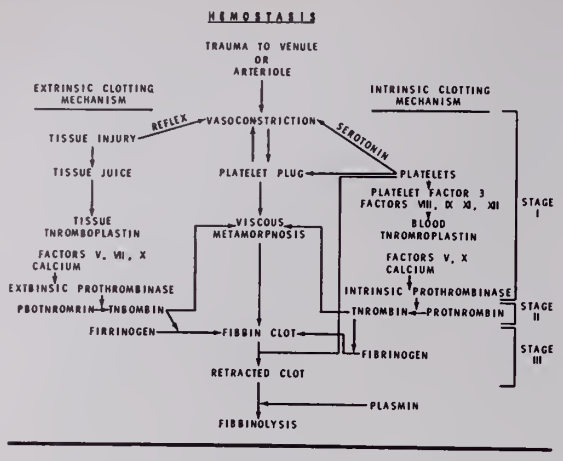


FIGURE I.

boring ones as well. This may be due to release of serotonin from the platelets.

Although the platelet plug can arrest bleeding, hemostasis is not secure until a fibrin clot is produced for re-enforcement. It is the conversion of the platelet plug into a permanent seal by the formation of fibrin that requires the plasma clotting factors. The formation of fibrin is accomplished in three steps. These are the three stages of coagulation, as distinguished from hemostasis. The stages of clotting are:

Stage I: The formation of prothrombinase

Stage II: The conversion of prothrombin to thrombin in the presence of calcium and prothrombinase, and

Stage III: The conversion of fibrinogen to fibrin in the presence of thrombin. This fibrin clot is the end product of hemostasis.

The exact mechanisms and pathways involved in hemostasis have not been completely resolved. The hemostatic flow chart in Figure 1 is highly diagramatic and represents an amalgamation of different coagulation theories that have proved practical in teaching the mechanism of hemostasis, the defects that can occur and the therapy indicated.

The central core shows the actual progression of hemostasis from trauma to blood vessels, through vasoconstriction, the formation of the platelet plug, viscous metamorphosis, the formation of the fibrin clot, the retraction of this clot, and in pathologic states the dissolving of the clot by fibrinolysis. The formation of extrinsic prothrombinase, which occurs in seconds, is shown on the left and that of intrinsic prothrombinase, which requires minutes, is shown on the right. Factors V and X are common to both intrinsic and extrinsic clotting. Factor VII is necessary only in the extrinsic process. Factors VIII, IX, X, XI and XII, along with platelets, are necessary for the intrinsic process.

Such an involved scheme of clotting is not easily retained by anesthesiologists with a limited background in hemostasis. The various plasma factors and their actions can be confusing and even more so lately with the change from eponymic to numerical designations. Because of this we have been teaching hemostatic defects in the light of the central progression of the formation of the clot. To review, this consists of platelet agglutination, viscous metamorphosis, the formation of the fibrin clot, clot retraction and in pathologic states fibrinolysis.

Diagnostic Tests

The diagnosis of hemostatic defects when considered in the present context can be made by:

1) Bleeding time: for diagnosis of defects of the vascular mechanism or platelets.
2) Clotting time: for a defect of formation of fibrin clot. This may be due to thrombocytopenia or a defect of plasma clotting factors V, VIII, IX, X, XI and XII.
3) Prothrombin time: this test does not measure prothrombin as such but the overall interaction of the plasma clotting factors.
4) Thrombin time: this is a measure of the conversion of fibrinogen to fibrin and is prolonged if fibrinogen is low.
5) Clot retraction: this is caused only by platelets and any defect in clot retraction is a measure of platelet abnormalities whether qualitative or quantitative.
6) Whole clot lysis: this test will show the presence of circulating fibrinolysins.

Abnormal results are obtained when:

a) The bleeding time is over 4 minutes
b) The clotting time is over 10 minutes in glass tubes
c) The prothrombin time is over 20 seconds
d) The thrombin time is prolonged over a normal control
e) Clot retraction has not begun in 30 minutes
f) Whole clot lysis has begun in 30 minutes and is marked within 60 minutes

If the clot completely dissolves in one hour fibrinolysis is severe and often fatal.

When these clotting tests are integrated into the central core concept, it is possible to make a clinical diagnosis that is sufficient for the therapy available at the present time. These tests have been correlated with the more complete results obtained from our hospital clotting laboratory and have been found to be adequate for diagnosis under clinical conditions.

To recapitulate: a prolonged clotting time may be due to a deficiency of platelets, plasma factors or fibrinogen.

A prolonged bleeding time indicates a defect of the vascular mechanism or platelets.

A defect of clot retraction indicates a deficiency of platelets.

Thus platelet deficiency can be diagnosed by a prolonged clotting time, a prolonged bleeding time and decreased clot retraction.

A prolonged prothrombin time is indicative of depressed plasma factors or unrecognized use by the patient of courmarin drugs. Thus a prolonged clotting and prothrombin time with normal clot retraction is indicative of a defect of the plasma clotting factors.

A prolonged thrombin time in conjunction with a prolonged clotting time is indicative of hypofibrinogenemia.

The last stage of the central core, the development of fibrinolysis, is indicative of circulating plasmin activity. Fibrinolysis may be accompanied by a prolonged clotting time or weak clot.

Abnormal bleeding can be expected, although it may not occur, in a variety of preoperative conditions. These include patients with hemophilia, thrombocytopenia, a history of bleeding during previous operations, liver disease, chemotherapeutic agents, and blood dyscrasias. Most commonly the patient who bleeds excessively at surgery has no recognizable defects by present criteria. It is presumed that the abnormalities are produced at the time of surgery and that these effects are compounded by the use of blood lacking normal clotting factors.

Hemostatic Defects

Voorhees and Elliott[1] found that the factors which contribute to abnormal surgical bleeding in the thrombocytopenic purpura patient are complex. They discovered that the amount of raw surface surgically produced was the greatest single factor determining abnormal bleeding. Specifically, in patients with idiopathic thrombocytopenic purpura bleeding occurred 50% of the time. 86% of those with an abnormal venous clotting time and 59% with a prolonged bleeding time bled. In general, the lower the platelet count, the higher the incidence of bleeding.

Abnormal bleeding also occurs in patients with polycythemia vera, myelofibrosis, multiple myeloma, leukemia and lymphosarcoma.

Severe bleeding occurs with incompatible blood transfusion. This is due to a depression of platelets, fibrinogen, and factors V and VII, subsequent to intravascular coagulation. This is followed by fibrinolysis, in an effort to halt and reverse the clotting process.[2]

Bleeding during extracorporeal circulation has decreased with experience and improved by-pass machines. Platelets drop rapidly during the first few moments of by-pass and then decline slowly during the remainder of the perfusion. Platelet deficiency alone is infrequently the cause of postoperative bleeding. There may also be a deficiency of clotting factors and increased fibrinolysis. Usually more than one simple deficiency is present when postoperative bleeding occurs after extracorporeal circulation. Gollub found only 27% of 35 bleeding cardiac patients had a single defect.[3] Gilbert[4] found a 12% incidence of bleeding with extracorporeal circulation but 7 of the 12 patients had identifiable bleeding points not clotting defects. Only one had a definite coagulation defect. Four patients had no surgical or coagulation problems demonstrated.

Karlson[5] evaluated 201 routine surgical patients and found 13 with abnormal bleeding. Seven of these had normal preoperative values, four had slightly abnormal values and only two had severe clotting disturbances.

Hemorrhagic diathesis is a major complication in uremic patients. The cause of bleeding in uremia is not well understood. It has been postulated as being due to thrombocytopenia, an increased thrombin inhibitor and prolonged prothrombin time. Fibrinolysis does not seem to be a factor.

Fibrinolysis occurs as plasminogen activator activates plasminogen and forms a proteolytic enzyme capable of breaking down various plasma proteins. Hence, if allowed to proceed

unchecked, multiple coagulation defects can occur. Increased plasminogen activator activity occurs during anoxia, pulmonary resection, portocaval shunt, stress, massive transfusion and in operations for cancer of prostate, uterus, and pancreas. Studies at Memorial Hospital have showed a correlation between the degree of surgical trauma and the development of fibrinolytic activity.[6] However, this may be a transient phenomenon and does not necessarily lead to excessive wound bleeding.

Patients who are operated upon after chemotherapy do not bleed unless thrombocytopenia has occurred.

Therapy

With a knowledge of the defects occurring in the formation of the clot and the diagnostic tests which localize the lesion, we can now consider the therapy.

Platelet defects require fresh platelets which can usually only be obtained from fresh blood less than four hours old. Special platelet concentrates can be obtained if sufficient notice is given the blood bank.

If plasma clotting defects occur, two choices are available. Fresh whole blood or fresh frozen plasma. Bank blood that is used within the first week after it is drawn is nearly as good as fresh blood, except for the missing platelets. Fresh frozen plasma will supply all of the plasma clotting factors, including the labile factors V and VIII, which are missing from bank blood over seven days old. All the other plasma factors are stable in bank blood under normal conditions. Anti-hemophilic plasma is an acceptable substitute for fresh frozen plasma and has the advantage in an emergency of not having to be blood type specific as is necessary with fresh frozen plasma.

Fresh whole blood is the ideal therapeutic agent. However, it is only indicated in conditions of thrombocytopenia and thrombocytopathia in the bleeding surgical patient. A sufficient amount of whole blood should be given to raise the platelet count of the recipient to at least 100,000/cc.

The remaining factors necessary for coagulation can be supplied by fresh frozen plasma. In the initial infusion, a sufficient amount of plasma should be given to raise the deficient clotting factors to 50% of normal. In the average adult this is at least 500cc of fresh frozen plasma.

Vitamin K_1 is seldom indicated in the operating room. If a patient has liver disease and a prolonged prothrombin time due to a deficiency of factors II, VII, IX and X the therapy should be started preoperatively. Fifty to 100mgm. of Vitamin K_1 requires at least four hours to produce an effect and the more slowly produced coagulation factors (VII, XI, and X) may not return to normal for 48 hours. The treatment of defects of the Vitamin K dependent factors is not Vitamin K but fresh frozen plasma.

Other hemostatic agents such as Adrenosem, Surgicel and Premarin have not been efficacious in the control of abnormal bleeding in our experience. The beneficial results reported in the literature have been inadequately controlled and are not at the present time convincing.

Fibrinolysis has been in our experience the most serious hemostatic defect. Before specific therapy became available, the mortality in this condition was high. In fact, the only therapy available was to complete the operation as rapidly as possible. This usually resulted in disappearance of clot lysis.

Our drug of choice in the therapy of fibrinolysis is epsilon amino caproic acid (EACA). The mechanism of action of EACA is on the activation of plasminogen to plasmin (fibrinolysin). It probably acts as a competitive inhibitor of plasminogen activator. EACA is usually given as a 5 gram dose intravenously. If fibrinolysis is still occurring a second 5 gram may be indicated, but 20 grams should not be exceeded. In our experience 10 grams is usually sufficient. The use of EACA for oozing without definite evidence of fibrinolysis may be dangerous. Myocardial infarction and cerebral thrombosis have been reported and there has been one case of each in our series of 200 patients who received EACA.

It has not been our experience that fibrinogen is required in non-obstetric conditions. Over a period of 12 years, in 2000 patients who received five or more units of blood, we have given fibrinogen twice. We have not been able to demonstrate abnormally low fibrinogen levels in patients with abnormal bleeding.

Management of Patient with Abnormal Bleeding

Most patients with abnormal bleeding receive large amounts of blood. Therefore, in cases in which extensive blood loss is expected a prothrombin time is determined preoperatively and a clotting time is determined immediately prior to anesthesia. Normal clotting times should be determined for each hospital. In glass tubes in our hospital it is 5 minutes and 52 seconds plus or minus 2 minutes and 9 seconds. This gives us a range of roughly 3 to 8 minutes as a normal clotting time. We assume a time above 10 minutes to be definitely abnormal. The clot is then observed for 30 minutes to determine the presence of clot retraction or fibrinolysis. After every five units of bank blood, clotting time, clot retraction and fibrinolysis are evaluated. After 10 units of blood, 500cc of fresh frozen plasma is given for every 5 units of bank blood as preventive therapy. If fibrinolysis occurs 5 grams of EACA in 150cc of normal saline is given over a 30 minute period and then the patient is re-evaluated for lysis. If clot retraction is inadequate then fresh whole blood is given. A platelet count may be done after inadequate clot retraction is found but in the operating room the fresh blood is given on the basis of clot retraction alone. Postoperatively the clotting time, prothrombin time, clot retraction and the presence of fibrinolysis is again re-evaluated and the suitable therapy instituted.

This routine has proven to be efficient in our hospital. We have had no deaths from clotting disorders in patients receiving less than 20 units of bank blood and only one death in 40 patients receiving more than 20 units of blood. The efficiency of this routine has led us to insist that a postoperative bleeding patient be returned to surgery if the clotting tests are normal. In all cases re-operated in the last two years a definite bleeding point has been found.

Summary

The use of the concept of the central core of the clotting diagram has enabled us to present a schema of hemostasis that is applicable for both teaching and therapy. Using this approach we have been able to control abnormal bleeding in the operating room and reduce the mortality associated with it.

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Management of Endometriosis†

Clayton T. Beecham, M.D.*
Danville, Pa.

Endometriosis occurs in about five per cent of women of reproductive age. Its symptoms and treatment of both moderate and severe cases are discussed.

ENDOMETRIOSIS is a unique gynecologic process. Like pregnancy, it is presumably a benign proliferating process capable of invading normal tissue. About 5% of women in the reproduction years have endometriosis. The diagnosis is not difficult and the medical management is easy in the average case.

Displaced or aberrant endometrium behaves somewhat like its counterpart in the endometrial cavity. The response to cyclic hormone stimulation is variable but usually resembles the proliferative phase.

Pain is a result of irritation in the involved areas through bleeding and growth of the process. Endometriosis is regarded by many as a cause of infertility. Whether it is the cause or the result of being infertile remains equivocal. Limited tubal and ovarian mobility, so common in endometriosis, logically would seem to favor sterility. And yet we have all seen conception take place where internal genitalia were so immobile with massive endometriosis that organ identification was impossible.

The symptoms and clinical manifestations of the disease do not present a unified pattern.

Symptoms

Commonly, pain before and during the menstrual period is the pattern. From one to fourteen days before the periods, lower abdominal discomfort (vague pulling or drawing sensations mixed with sharp, steady aching) appears. Acquired or increasing dysmenorrhea is the symptom most often attributed to endometriosis. Variations in the pain pattern are to be expected. At times discomfort is only during a period while again it may extend through the full cycle.

Dyspareunia and rectal tensions are regularly encountered while postcoital bleeding, hypermenorrhea, hematuria or rectal bleeding are not frequently met.

The anatomical areas involved largely determine the symptoms that develop. The uterosacral ligaments, particularly where they attach to the posterior surface of the cervix, and the ovaries, are the most common sites for minimal disease. As the process extends and proliferates, the paracervical areas, the posterior surface of the cervix and the cul-de-sac create a confluence. Not only is the space between the rectum and the cervix obliterated, but a painful, nodular, fixed mass is formed. We understand how a lesion that proliferates and fixes to this extent produces pain. On the other hand, the very same amount of endometriosis in this highly sensitive area can be present without producing symptoms.

Pelvic Examination and Findings

The generalized pain and tenderness to palpation often make an exact assessment of involvement difficult. The classical bimanual examination has serious limitations because of vaginal wall thickness. However, rectovaginal-abdominal palpation makes possible a three-dimensional appraisal and greatest accuracy of examination. There are three other entities to consider in making a differential diagnosis:

1. Pelvic congestion syndrome. Here the uterosacral ligaments are thick, tender, and rather tense. The corpus uteri is often in the cul-de-sac, slightly enlarged and tender to touch. To distinguish from endometriosis, note the absence of nodularity and the lack of genuine rigidity in the involved areas.

†*Presented at the Second General Scientific Session of the Kentucky Medical Association Annual Meeting in Louisville September 21-23, 1965.*
**Director of the department of gynecology and obstetrics at Geisinger Medical Center, Danville, Pa.*

2. Pelvic inflammatory disease. Endometriosis and p.i.d. are more difficult to tell apart. In general, inflammatory disease has a smoothness of the involved areas and is perhaps less painful in addition to providing a history of recent lower genital tract infection.

3. Carcinoma of the ovary with cul-de-sac involvement. Here there is little of the tenderness and frank pain on palpation and rarely the history of pain, so common in endometriosis. Ovarian endometriosis without neighboring pathology, causing asymptomatic cystic formation, cannot be diagnosed accurately by pelvic examination alone. The presence of such a mass makes laparotomy mandatory.

Medical Treatment

Paradoxical as it may seem, all patients with endometriosis do not require treatment. The purpose of treatment is to relieve discomfort and to preserve fertility. Since pain is the most common symptom of endometriosis, we are fortunate to have a variety of pain-relieving drugs to prescribe.

Mild and moderately severe cases of endometriosis can be treated physiologically by inhibiting ovulation. The sharp drop in progesterone secretion at the end of the ovulatory cycle favors the spread and growth of endometriosis; inhibiting ovulation, thereby preventing progesterone withdrawal, favors regression of the disease. Ovulation can be prevented by pregnancy or, when this is impossible or undesirable, by using any of the estrogen-progestogen combinations commonly used as oral contraceptives.

Treating Severe Endometriosis

Severe endometriosis requires a stronger regimen to prevent ovulation. Stilbestrol has proved to be the least expensive and the most efficacious preparation despite the glamor attached to newer preparations. In severe cases, when pregnancy is not feasible, amenorrhea lasting ten months is a workable substitute. During this long period of amenorrhea, endometrial implants fade away in a process of decidual necrosis.

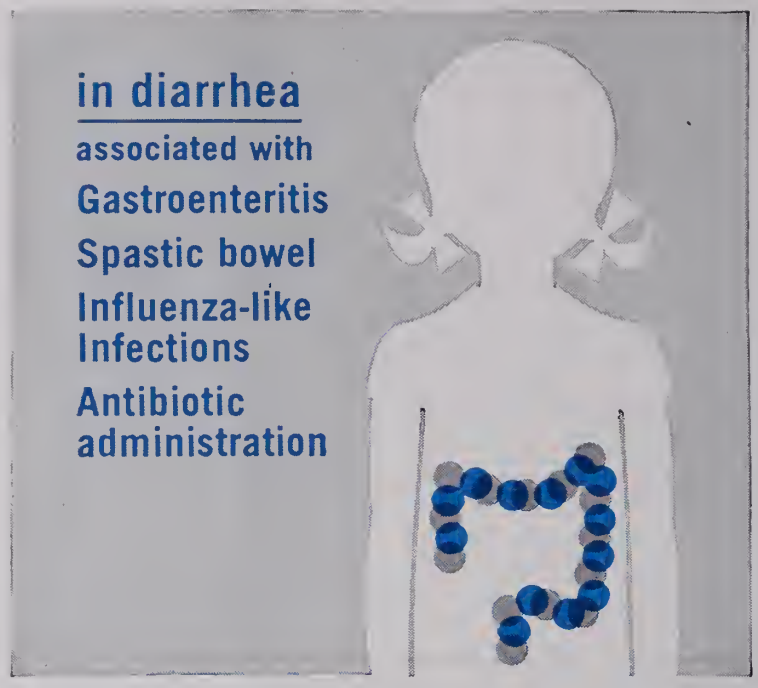
In order to minimize the gastrointestinal disturbance associated with the use of stilbestrol, I recommend the enteric coated tablets, taken at bedtime in the following doses:

0.5 mg. daily for 5 days
1.0 mg. daily for the next 5 days
2.0 mg. daily for the next 5 days
4.0 mg. daily for the next 5 days
10.0 mg. daily for the next 10 days
25.0 mg. daily for the next 21 days

The dose is increased to 50 mg. a day and maintained for one month. When or if breakthrough bleeding occurs another 25 mg. of stilbestrol is added to the daily dosage. Even though bleeding does not occur, an increase of 25 mg. each month should be added to the total stilbestrol dose schedule. Stilbestrol doses of 250 mg. to 500 mg. are not only easily tolerated but they are enjoyed by the patient. Comfort and freedom from pain are so greatly appreciated that patients have no objection to taking a handful of pills once a day. Sometimes a copious, clear mucoid discharge becomes a problem during treatment, but this can be counteracted with acetic acid douches.

In severe cases of endometriosis, 12 to 16 weeks of induced amenorrhea may pass before the last palpable remnants of endometriosis disappear. However, the program should be continued the full ten months, then stopped abruptly. There will be slight withdrawal bleeding two to three weeks after discontinuance of the drug and four weeks later a normal menstrual period.

Endometriosis is unpredictable. The period of regression following a prolonged period of amenorrhea varies with each patient. Fortunately, if it becomes active again, a second course of stilbestrol may be employed without harmful effects. I have used this regimen three times in one woman; following the last course of treatment neither symptoms nor palpable evidence of endometriosis has returned.



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diphenoxylate hydrochloride .....2.5 mg.
(Warning: may be habit forming)
atropine sulfate .....0.025 mg.

age: For full therapeutic effect—Rx full apeutic dosage. The recommended ini- *daily dosages*, given in divided doses, l diarrhea is controlled, are:

ldren:
to 6 months—3 mg.
(½ tsp* t.i.d.)
o 12 months—4 mg.
(½ tsp. q.i.d.)
1 to 2 years—5 mg.
(½ tsp. 5 times daily)
2 to 5 years—6 mg.
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5 to 8 years—8 mg.
(1 tsp. q.i.d.)
to 12 years—10 mg.
(1 tsp. 5 times daily)

lts: 20 mg. (2 tsp. 5 times daily or 2 ets 4 times daily)

sed on 4 cc. per teaspoonful.

ntenance dosage may be as low as one th the therapeutic dose.

:autions: Lomotil, brand of diphenoxy- hydrochloride with atropine sulfate, n exempt narcotic preparation of very addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

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SEARLE

Research in the Service of Medicine

Prevention of Serious Injuries: Mouthguards for Athletes†

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A review is presented of the types of mouthguards which have been fabricated for participants in contact sports, with suggestions for other uses. Their importance in the role of protection against minor and serious injuries to the teeth and supporting structures is emphasized.

CONTACT SPORTS have been a source of enjoyment to both participant and spectator for centuries. As new games and contests have been initiated, new types of protective equipment have been developed to minimize the injuries which might be incurred.

At present when one thinks of contact sports, probably the one which first comes to mind is football. In the last decade, football may have become our national pastime. It is now played, watched and enjoyed by millions of people every year. Since the advent of this sport, much work has been done by coaches, trainers, the medical profession, and researchers to develop protective equipment. The wearing apparel of the modern day gladiator is a far cry from what his grandfather or even his father wore onto the gridiron. The introduction of plastics has done much to change the gear. For example, the present helmet and shoulder pads provide much more protection and comfort than those of an earlier vintage.

The healthy, well conditioned, superbly trained body is probably the best insurance against injury. This is provided by many hours of weight lifting, isometrics, calisthenics, training tables, wind sprints, early curfews, spring training, proper diet and fall practice. With everything directed toward developing this "hunk" of muscle physically and preparing it psychologically to annihilate another on Saturday afternoons, is it any wonder that the masticatory apparatus received little attention until recently?

Scope of Problem

Historically, we do not know to whom credit should be given for having perfected the first mouthguard. However, within the past ten years much has been done to perfect a type which would offer suitable protection to the teeth and supporting structures and still enable the wearer to enjoy proper breathing without fear of aspiration, and some degree of understandable enunciation. Myriad types have been introduced, experimentally tried, and discarded for one reason or another. Many "commercial" types (not custom made) are entirely too bulky and do not offer the desired protection.

> "A survey made by the Security Life and Accident Company shows that injuries occur to one out of five participants in sports. Of these injuries, 86.3 per cent occur in football. Thirty-seven per cent of football injuries are incurred by first year players, 32.5 per cent by second year players, 22.3 per cent by third year players, and only 8.2 per cent by the more experienced fourth year players.
>
> "In the 1954-1955 'Handbook of the National Federation of High School Athletic Associations' football injuries are listed as follows: face and dental, 53.9 per cent; knee, 19.6 per cent; shoulder, 13.7 per cent; head, 9.7 per cent; and pelvic 3.7 per cent.
>
> "Schools spend on an average $90 to $120 annually to outfit each football player with protective clothing, which affords him protection only for those regions in which 48 per cent of the injuries occur. A comfortable, well-fitting mouthpiece costs less than a pair of football shoes."[1]

†*Presented at the Second General Scientific Session of the Kentucky Medical Association Annual Meeting in Louisville, Kentucky, September 21-23, 1965.*
**Professor and chairman, department of prosthodontics, University of Louisville School of Dentistry.*

In a report of survey of coaches by the Missouri Dental Association it was revealed that only 19 per cent of the boys wore protectors fitted by dentists. Most of the dental participation consisted of making impressions for the fabrication of custom made guards. However some dentists helped in the fitting of stock protectors. Fourteen per cent of the coaches were unfavorable to protectors, for varying reasons.[2] One comment which was received was that it made the players soft and they didn't hit as hard. It also cushions the shock to the occlusal surfaces of the teeth and they don't hit as hard.

In speaking of injuries, we do not necessarily have reference to only mechanical injury to the teeth and other oral tissues. According to a recent study at the University of Kentucky Medical Center, mouthguards also reduce pressure waves to the brain and bone deformation, thereby reducing greatly the number of concussions.

The following is from a study at Notre Dame, the School that Life Magazine made famous by its picture of the toothless wonders:

> "The success of this mouthguard (custom-made modified vinyl elastomer guard) in reducing injuries led to its use by the Notre Dame team during the entire 1963 football season. Following is a summary of the teeth, head and neck injuries reported:
>
> "*Injury to the dentition*—All four minor teeth injuries that occurred during the 1963 season involved boys who were not wearing mouthguards.
>
> "*Head Injury*—There were ten concussions, and in only one instance was the player wearing a mouthguard. He was Bob Lehmann, captain of the 1963 team and an enthusiastic advocate of mouthguards, with a history of many previous concussions.
>
> "*Neck Injury*—Neck injuries had increased since the use of the face bar had become mandatory. During the 1962 season at Notre Dame, six or seven players had chronic neck problems, and four of them wore cervical collars. Cervical traction was routine therapy for these players. Not a single player who faithfully wore his mouthguard during the 1963 season found it necessary to wear a cervical collar."[3]



FIGURE 1. Stock.

Dentistry has become especially interested in mouth protectors as a result of the January 1962 ruling of the National Alliance Football Rules Committee: "Each player shall wear an intra-oral mouth and tooth protector which includes both an occlusal and labial portion. It is recommended that the protector be: (1) constructed and fitted to the individual by impressing his teeth into the mouth and tooth protector itself; or (2) constructed from a model made from an impression of the individuals teeth."

Types of Protectors

The mouth protectors may be classified as follows: (1) Stock variety (those not custom made), (2) mouth formed protectors (manufactured kit with tough shell and resilient liner) and (3) custom made protectors fabricated by dentists (See Figures 1, 2 & 3). According to several polls which have been taken the custom made protector is superior in many respects such as retention, comfort, ease of speech and breathing, tear resistance, and protection for teeth, gums, and lips. Of the many types of custom made protectors, those constructed of resilient acrylic resin and silicone vinyl seem superior in the above mentioned respects.

The method of construction for the vinyl type custom made protector may be outlined as follows:



FIGURE 2. Mouth-formed.

(1) Examine the mouth carefully and do dental prophylaxis as necessary, to prepare the mouth for impression procedure.
(2) Make impression of maxillary or mandibular arch depending upon which the mouth protector is to be worn (generally the maxillary arch).
(3) Pour cast, separate and outline with pencil the areas which the mouth guard is to cover.
(4) Heat vinyl in boiling water until softened. Remove from water and center over cast.
(5) Place the top portion (plastic ring with rubber dam) over the softened vinyl and cast, making air tight contact with the base of the suction apparatus.
(6) Pull vacuum to adapt softened vinyl to cast and when adapted chill in cold water.
(7) Release vacuum and remove mouth protector from cast.
(8) Trim with scissors to the previously determined penciled outline.
(9) Try in mouth. Remove and polish trimmed peripheries with open flame.
(10) Instruct athlete in care and use of protector.

It is dentistry's responsibility to develop better mouthguards with due consideration of all the traumatic forces which can be transmitted through the teeth and condyles. It is the coaches' responsibility to see that the best type protection is provided. It is the player's responsibility to wear the mouth protector and care for it, and enforcement of this rule is up to the game officials. All types of mouthguards offer some degree of protection, however, the custom made type is superior in all respects. Regardless of the type protector which is to be used, dentists should fit them. The coach, the player or team manager cannot and should not be expected to assume this responsibility.

The future for mouth protectors looks bright and seems to hold much promise. Already many uses have been discovered in addition to their role as protection against injury. Research has proven their worth in caries control used in conjunction with a fluoride gel plus antibiotics placed inside the mouthguard and worn for only a few minutes each day. Mouth protectors are advantageous for use in general anesthesia procedures such as orotracheal and nasotracheal intubation. They will prevent trauma to the maxillary anterior teeth and are especially indicated when prosthesis and restorations such as fixed bridges and porcelain jacket crowns are present on the upper anterior teeth.

(Continued on Page 262)



FIGURE 3. Custom-made.

Appendectomies: A Five-Year Epidemiologic Review†

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Lexington and Berea, Ky.

An epidemiologic study of 400 appendectomies done at a rural hospital is presented. The findings are compared with the results of other studies and the similarities and variations are discussed.

IN RECENT YEARS a number of studies from the United States and elsewhere have documented the declining rate of appendectomies. These reports have described a real decrease in both the incidence of and mortality from acute appendicitis, not only nationally but also in various geographic sectors.[1-7]

The purpose of this communication is to describe the experience in a small rural hospital with respect to this disease and compare this with previous studies.

Method

The method employed in this study was to review pathology reports, surgical reports and the medical record file at Berea College Hospital covering a five year period from July 1, 1959, to June 30, 1964. The total number of major surgical procedures, primary and incidental appendectomies, and the pathologist's diagnosis on the appendiceal tissue removed was recorded for each person.

During the period studied 95% of the appendectomies were done by the same surgeon and 95% of the tissue diagnoses were made by the same pathologist.

The patients of this hospital consist of residents of Madison and surrounding counties and the students of Berea College. The college is coeducational, with an enrollment of about 1800. The number of males and females is approximately equal. Most of the students come from the southern Appalachian region of the U.S.

Results

During the period reviewed 400 appendectomies had been done at the College Hospital. Two hundred and seventeen of these operations were primary procedures and 183 were incidental appendectomies at the time of other procedures, e.g. tubal ligations, hysterectomies, etc.

Primary appendectomies made up 17.7% of all major surgical procedures. The number of major surgical procedures did not vary significantly from year to year. Although the percentages of appendectomies varied somewhat, there was no definite trend. (Table I). There were no deaths.

TABLE I

PROPORTION OF MAJOR OPERATION DUE TO PRIMARY APPENDECTOMIES

YEAR	1959 (7-1 to 12-31)	1960	1961	1962	1963	1964 (1-1 to 6-30)	TOTAL
No. of Major Operations	145	207	260	245	237	131	1225
No. of Appendectomies	27	42	41	50	31	26	217
Percent	18.6	20.3	15.8	20.4	13.1	19.8	17.7

Most of the appendectomies for acute appendicitis were in the 16 to 20 age group. The average age of patients who had primary appendectomies was 23.3 years. (Figure 1) The age with the highest incidence of acute appendicitis, 14 cases, was age 14. Ap-

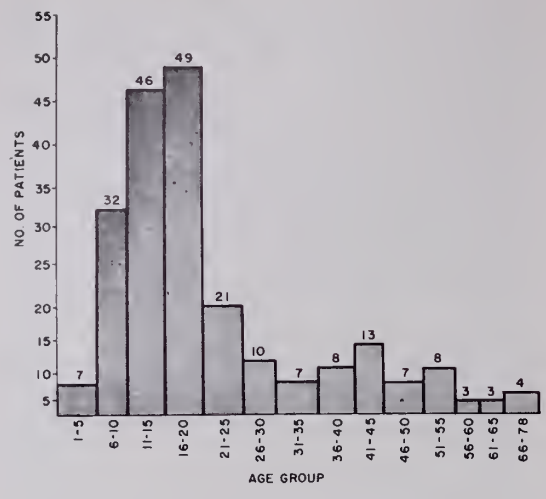
†*From Berea College Hospital and the department of community medicine at the University of Kentucky College of Medicine. This study was done in partial fulfillment of the Senior Student Clerkship in Community Medicine (Doctor Points) supported by the Commonwealth Fund of New York.*

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AGE DISTRIBUTION OF ACUTE APPENDICITIS



pendectomies for acute appendicitis are relatively uncommon below the age of 6 and after the age of 25. The rates for males are consistently higher for each year except 1961, when the number of appendectomies done was about equal for each sex. (Table II).

TABLE II

TOTAL NUMBER OF APPENDECTOMIES AND PATHOLOGICAL FINDINGS BY SEX AND YEAR

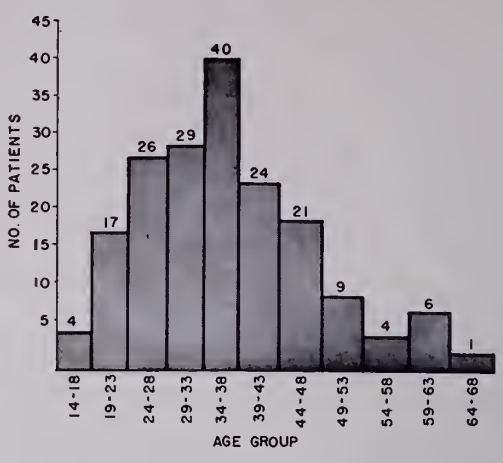
Year	Male/Female Ratio	With Path. Male	With Path. Female	Without Path. Male	Without Path. Female	Total
1959 (7-1 to 12-31)	1.7	16	9	1	1	27
1960	1.7	24	14	0	4	42
1961	0.9	17	19	0	5	41
1962	3.0	33	11	0	6	50
1963	1.8	16	9	4	2	31
1964 (1-1 to 6-30)	1.3	13	10	1	2	26
TOTAL	1.7	119	72	6	20	217

Of the 217 operations for acute appendicitis, 26 appendices were reported normal by the pathologist or 12% of the appendices removed over a five year period. There were 20 normal appendices in 92 operations on females, giving a diagnostic error of 21.8%. In 125 operations on male patients, only 6 appendices were reported normal, for an error of only 4.8% (Table II). This difference between the results obtained in male and female patients is statistically significant when the Chi square test is applied (Table III).

Incidental Appendectomies

Figure 2 shows the age distribution of appendectomies incidental to other major surgical procedures. The age group with the highest incidence, 34-38, is greater than that for acute appendicitis. Only six of these operations were

AGE DISTRIBUTION OF INCIDENTAL APPENDECTOMIES



on male patients. Of these 183 incidental and thus presumably "normal" appendices, 44 showed pathological changes varying from healed appendicitis to fibrosis. In addition, six others harbored pinworms in the appendiceal lumen, apparently without symptoms. Two of the appendices with pathological changes also harbored pinworms. Therefore, 24% of appendices removed prophylactically showed evidence of pathology. (Table IV).

Discussion

This study, covering a five year span, did not reveal any decreasing trend in acute appendicitis. This finding is at variance with many studies over longer periods that have unquestionably demonstrated the decreasing incidence of this disease both nationally and locally.[1-4]

The fact that no decrease was observed may indeed be related to the short study period and longer observations may show a downward trend. Nevertheless, Behrend[5] in a four year study was able to demonstrate a near 50% drop in the incidence of appendicitis from 1955, when this condition accounted for 8% of surgical admissions, to 1959, when a little

TABLE III

PATHOLOGIC DIAGNOSIS OF THE APPENDIX FOLLOWING OPERATION FOR ACUTE APPENDICITIS IN MALE AND FEMALE

Sex	Appendices with Pathology	Appendices With No Pathology	Acute Total Appendectomies
Male	119	6	125
Female	72	20	92
TOTAL	191	26	217

$X^2 = 14.50$
$P < .001$

TABLE IV

NUMBER OF INCIDENTAL APPENDECTOMIES WITH PATHOLOGICAL CHANGES

Year	Number of Appendectomies	Number With Pathology	Percent Pathological	Number with Pinworms Without Pathology
1959 (7-1 to 12-31)	21	4	19.0	1
1960	34	7	20.6	1
1961	38*	13	34.2	0
1962	32	3	9.4	2
1963	35	9	25.7	2
1964 (1-1 to 6-30)	23	8	34.8	0
TOTAL	183	44	24.0	6

* 2 appendices with pathological change harbored pinworm

over 4% of surgical admissions were due to appendicitis. Furthermore, the percentage of appendectomies observed in this investigation is unusually high, ranging from 13% to 20%. Most studies report a range from 2% to 3% at present. The high rate of appendicitis may be related to the predominately young population which this rural hospital serves. But, the *continued* high rate is suspicious. Whether this is due to the short observation period or is a reflection of an uniquely susceptible population is an intriguing question. The students at Berea are representative of the lower income population of Southern Appalachia. Familial and genetic determinants of appendicitis have not been thoroughly studied. Such studies might be rewarding in explaining a high incidence of appendicitis in a particular population.

The difficulty in diagnosis of pathologic changes, both acute and chronic, in the female pelvis is well known. This study illustrates this by revealing that over 20% of the diagnoses of acute appendicitis were in error when dealing with women, and only 4.8% were wrong in the men. These findings agree with those of Thieme[4] who reports a 20.6% error and states that the range in error is from 4% to 40%. He does not differentiate the rate of error in male and female patients. In a study of appendicitis in the National Health Service Hospitals in England, Lee points out an excess of appendicitis in the female aged 14 to 26 and believes this due to diagnostic error. Similar observations have been made by American investigators[7] who also point out that, if only pathologically proven appendicitis is counted, the male predominates in all age groups. The Berea Hospital experience does not contradict these findings. The male/female ratio of appendectomies was greater than one in all years with the exception of 1961. This minor variation could be accounted for by the small sample. (Table II)

With rare exception an infectious disease may be apparent or inapparent, acute or chronic. The ratio of apparent to inapparent in appendicitis is unknown but it was surprising to discover that almost 24% of the appendices removed prophylactically had pathological changes. Table II shows that more appendectomies were done on males than on females. This high ratio could be explained on the basis that the disease in the female tends to be milder or inapparent. But the number of incidental appendectomies on male patients is not sufficient for a valid comparison.

Some investigators offer the widespread use of antibotics and better nutritional standards as possible reasons for the decrease in appendicitis, but the precise manner in which such influences might operate remains obscure. If they are responsible, it may be that the decrease is associated with a relative increase in less virulent infection, producing more inapparent disease.

A continued surveillance of appendicitis in this rural community might eventually demonstrate a downward trend. Also, as one investigator observed,[3] a downward trend may be associated with a shift in age to include more of the older population. The results of similar studies in other rural Kentucky hospitals might be valuable in interpreting the long range trend of this disease.

Summary

The pertinent findings in this descriptive epidemiologic study were:

(1) An absence of a downward trend in the number of appendectomies despite an observed decrease nationally.

(2) Over a 20% error in the diagnosis of acute appendicitis in the female as compared to 4.8% in the male.

(3) Forty-four or 24% of "normal" appendices removed prophylactically showed pathological change.

The implications of these findings were discussed.

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(Continued on Page 258)

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Olfactory Hallucinations—Clinical Evaluation

Nina Kateryniuk, M.D.†

Introduction

ALTHOUGH vague olfactory hallucinations such as smelling "gas" or "bad odors" or "electricity" are not uncommon among schizophrenic patients, the case reported below presented a rather complex, rare, and isolated hallucinatory experience in that it was limited to olfactory and, to a lesser degree, gustatory senses.

Case Report

A 46 year-old white, married male, father of four children, was admitted to the psychiatry ward at Louisville General Hospital on a voluntary basis. He had been unemployed for three weeks prior to admission. His last occupation was that of a janitor.

Chief Complaint: "I need help for my nerves. I have smells that I can't understand."

Present Illness: The patient dates the onset of the presenting symptoms back to approximately 1956 when he rather suddenly began experiencing nonspecific odors which he could best describe only as "the air around me smelled funny—not like any particular smell I ever smelled before." This continued several months, the patient initially feeling somewhat disturbed but not overly concerned. However, after about five months he noted that the odors occurred only when he was around women. He could now describe the odor best as "the odor that comes after a woman." The odors were not very disturbing and when he "picked them up" he began to feel "trembly inside" and would "occasionaly get an erection and discharge." He could get some relief from the odor by "blowing it away", but this soon began to fail and there was nothing he could do for help. Accompanying some of these symptoms was a dull, aching pain in the right lower portion of his abdomen. This he described as pain from "sperm backing up in my tubes." On occasions he relates this being almost unbearable, but denies he was ever able to find any relief from the pain. The symptoms persisted and remained essentially unchanged since they began. The frequency, duration and severity of symptoms varies considerably but usually he can count on "picking up the scent" two or three times per day if he has much contact with women. Usually he has to be in the same room with the women and on every occasion there has been more than one woman present. He is unable to determine which woman is "putting out the odor." The patient states that women have told him they can "feel him across the room and he gets them all shook up." He definitely feels he has some mysterious feature which attracts women to him and makes them "desire" him.

He has also experienced odors from men in the last three or four years, although they are not as frequent and do not affect him so severely. This odor is described as the odor a man has after intercourse. Again these are usually apparent only when more than one man is present in a room and the patient is unable to tell where the scent is coming from. He is able to control these somewhat satisfactorily by "blowing the scent away" when he feels it is coming on. However, if he is not able to blow this away he experiences a "terrible taste" which he can get rid of by washing his mouth out with water. One particularly unpleasant experience he relates occurred while he was performing his duties as a janitor and one of his bosses was sitting nearby. He "picked up the odor" and then began to feel "like I had a penis in my mouth and was choking to death."

He feels it is necessary for a man to have an erection before he can "pick up the scent" from him. He has been asked on several occasions if he is trying to get "rich" by different men. This he interprets as a desire on their part for homosexual activities with him, "getting rich" on his service fees.

His problems became so overwhelming four years ago that he went to Florida, quitting his job in his hometown and becoming a janitor there. He found no relief since there were so many widows who desired him.

Three weeks prior to admission he came to Louisville hoping to find some help. However, he has gotten "all shook up" and made three trips back to Florida. Each time he was trying to "get away from those smells." Needless to say, this didn't help since he could even "pick up the scent" as he drove through a town.

Family History: His mother died at 40 years of age of a brain hemorrhage. She was described as very nervous and sick all her life. His father, a farmer, is 72 years old, living and well. His step-

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mother is 55 years old, living and well. Patient has three siblings and one half-sibling, all of whom are in good health.

There is no known history of any serious infectious disease, venereal disease, cancer, metabolic disorders or mental diseases in the patient's immediate family.

Family life at home with his parents is described as pleasant with little friction. The family is regarded as rather close. The patient felt no particularly strong attraction toward either parent, feeling, however, somewhat sorry for his mother since her health was bad. She died when he was 19. The children often had to do much of the work normally done by a farm mother.

Previous History: As an infant, the patient was obese and did not walk until he was 18 to 24 months old. He had most of the usual childhood diseases, except for measles which he had without sequelae in the service in 1942. In 1946 he was diagnosed as having "ulcer in lower portion of stomach" and was treated with and still uses Maalox. In 1962, he spent 30 days in a V.A hospital for stomach discomfort and nervousness. At this time no mention was made of odors.

The patient spent 22 months in active combat during World War II beginning at Normandy Beach and moving to the Elbe River. He suffered "shell shock" two times and was taken off the line one time during heavy combat.

Marital History: He was first married when 28 years old to an 18 year-old girl he had known for 12-14 years. Marriage produced one son now 17 years old and living with an aunt. The patient denies premarital relations with wife and felt there was strong love between them, with complete family agreement and no religious conflicts. Initially they were very happy, but after one year his wife was unfaithful to him. He relates she had acquired a "bad name" before he married her, but he was unaware of this. He divorced her after two years of marriage, receiving custody of their child. For 18 years following the divorce he had numerous encounters with prostitutes. In 1956 after a one-year courtship he married his present wife, whom he had met through family friends. He denies any premarital sexual relations. His present wife (32 years old) was a divorcee with one child. They have four children of their own. At present he is very happy but describes his wife as "cold natured."

The patient experienced the onset of puberty at 12-13 years of age. His knowledge of sex was acquired through his peer group. His first heterosexual experience was at 19 years of age with a prostitute. He occasionally indulged in masturbation. He denies any homosexual experiences.

Education: The patient started school at age six. He failed the fourth grade because of illness. He skipped the fifth grade and quit after the ninth grade. The patient said he liked school and got along well with his teachers but was somewhat shy and retiring. He describes himself as an average student, but better than average in arithmetic. He could not list any particular ambition; he only knew he didn't want to farm.

He tried to get some further education through a correspondence course, but gave up when the material became too complicated for him.

Religion: The patient's parents were religious and attended church regularly. He regards himself in need of more religion and wants to get back in church activities. Religion has never presented any real conflicts in his life.

Vocation: Patient has had numerous jobs throughout life. The best job he had was as a sprayer and metal finisher. However, he missed a lot of work because of "nervousness" and "I can't stand cold weather." He feels that they might have let him go because of his chronic absenteeism if he hadn't quit. He was never dismissed from any job. Each time he left place of employment was because of low pay or he was laid off.

Recreation: He formerly liked to hunt and fish. He now has little interest in either.

Living Conditions: Recently he was making $1.25 per hour as a janitor. His wife works part-time. He describes finances as close, but there is no real difficulty.

Review of Systems: The patient sleeps poorly and has a poor appetite. He is 5'9" tall and weighs 107 pounds. He lost ten pounds in the last year. He smokes one pack of cigarettes per day. He denies the use of alcoholic beverages.

Physical Examination: The patient is a well developed, undernourished male. There were no gross abnormal findings on physical and neurological examination.

Laboratory Data: Routine tests were not remarkable. Spinal fluid examination showed no abnormal findings.

Formal Mental Examination: The patient had a cooperative attitude. He was calm and adapted well to examination, attempting to answer all questions to the best of his ability. There were no extraneous motor movements.

His description of symptoms was presented in a coherent, logical sequence. His sole concern was with illness, this seeming at present to control his entire life. The patient was productive with a good flow of thoughts and very attentive to questioning.

There was little display of affect. However, it was noted that he often smiled somewhat inappropriately and seeming to realize this, would make an attempt to change his expression. Verbally he seemed to show appropriate affect for his family, people in general, and his work.

There were indications of a persecutory trend, the patient feeling that odors were sent out by individuals, and therefore that other people were responsible for his illness. He felt people were often talking about him and often believed people were paying an excessive amount of attention to him. He continued to experience olfactory hallucinations and elaborated on them as above.

The patient was well oriented in all spheres. He seemed to be functioning in a normal range of intelligence.

Course in Hospital: The patient appeared preoccupied and behaved in a withdrawn manner. His facial features often expressed tension and suffering.

He was cooperative and polite but seemed suspicious and was reluctant to talk to other patients. His appetite was poor. He claimed that he was not able to sleep; however, his sleep record indicated that he rested well at night. He was treated with tranquilizers and ECT with gradual improvement. Upon his discharge the patient was free from olfactory hallucinations and delusions, participated in ward activities and denied having any complaints.

Discussion

Clinical Consideration: The incidence of olfactory hallucinations is reported in a great variety of psychiatric disorders. They include pathological processes of organic as well as so called psychogenic origin. Among the organic causes the following are considered: 1, tumors or lesions of temporal lobes; 2, epilepsy; 3, cerebral lues; and 4, vascular insufficiency or other factors disturbing the total hemodynamics of the cerebral circulation. In the psychogenic group, severe psychoneurosis of compulsive type and schizophrenia most commonly produce the symptom. It is quite difficult at times to differentiate between an organic and a psychogenic basis for these symptoms. A patient often cannot be specific about the smell, describing it as "unpleasant, peculiar, funny, etc." In organic disorders, however, patients are more likely to have other symptoms related to the central nervous system such as dizziness, confusion, headaches and personality changes.

The olfactory hallucinations found in patients with psychoneurosis of the compulsive type may be explained in both psychological and physiological terms, depending upon the orientation of the investigator. It is assumed by some to result from an affective state with involvement of the orbital regions of the frontal lobe. Others attempt to interpret it as a recall of a formal affective state of disgust or a rejection of an unpleasant situation. It is a fact that the olfactory hallucinations reported in this type of neurosis are as a rule unpleasant and disturbing. In psychoanalytical concepts there are referrals to psychosexual conflicts, guilt, anxiety and regression. There is still a great deal of controversy about the incidence of olfactory hallucinations in schizophrenia. Many psychiatrists have observed that they coexist with other types of hallucinations and are rarely present as isolated phenomenona. The common opinion is that auditory and visual experiences occur more frequently than gustatory or tactile hallucinations. Others have stated that olfactory hallucinations are as common as auditory.

Therapeutic Consideration: As evident from the above discussion, the treatment will depend on clinical diagnosis. In the case reported above, the final diagnosis of schizophrenic reaction, paranoid type, was made and the patient was treated symptomatically with tranquilizers and ECT. He was discharged free from symptoms; however, the follow-up in the outpatient clinic indicated that the improvement was transient. The patient was advised to return for hospitalization; however, he decided to seek admission to the Veterans Administration Hospital.

Perhaps it would be well to summarize by a quotation from G. M. Davidson: "The complexity of the relationships is great when we recall that various olfactory tracts and connections with the hypothalamus and thalamus correlate general somatic, visceral sensory, gustatory, optic and tactual systems. The elucidation of the problem is obviously a matter for the future."

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Be Sure to

Make Your Reservations Now

for the

1966 KMA Interim Meeting

April 13 & 14, DuPont Lodge, Cumberland Falls

(See story, page 244, for details)



Changing Concepts in the Health Field†

Austin Smith, M.D.*

IMPORTANT changes that affect the health field are taking place in our country—many of them far outside the professional environment in which we as physicians are most at home.

What are these forces that are causing changes in the health field?

How do they affect the medical profession?

We will find them all around us, among our friends and neighbors, in our town councils, at the State House in Frankfort, and, perhaps most of all, in Washington among our elected Representatives and in the sprawling government departments that regulate so many of our affairs.

The ebb and flow of these forces can directly affect you both in your professional practice and as citizens in your nonprofessional life. And it seems to me that lately they have been flowing more than ebbing, and that things in too many instances have been worse, not better.

Public Interest

There is one basic concept that no physician can afford to overlook, trite as it may sound at first mention. Nor can this basic truth be forgotten by the pharmaceutical industry. This is the part that the general public is becoming more and more interested in individual and public health. Men and women everywhere have come to believe that their health and the health of all our people is a matter of the public's interest. Furthermore, they are no longer willing to leave the problem of their own, their family's or their community's health to "the experts." They are having their own say about it, and we "experts."—medical doctors, pharmacuetical manufacturers, leaders of pharmacy, hospital administrators, the whole health team—must try to make sure the public has the facts on which to make good judgments.

We have also been witnessing another crucial change—the development of new attitudes among those in government. Our elected Representatives, high officials of the executive departments and the staff associates of both now recognize that expressing interest in matters of health is in the public interest and that it's mighty good politics too.

It is not often that acknowledged public interest and unmistakable political interest so neatly coincide in a kind of "Cause celebre" in which all can enlist.

For the elected official, a good cause can be the key that opens the door to public office, or keeps it open.

For the appointed executive of a government department, the good cause can be the key to an empire of his own. What bureaucrat wouldn't toy with grabbing this kind of key to a "golden door"?

The new and expansive federal role in the health field is dramatically evident in dollars and cents. The government's new telephone-book-size budget provides for health services and health research programs of the Department of Health, Education and Welfare alone the staggering sum of two billion, five hundred ninety-one million dollars (fiscal year 1966).

Ten short years ago, the Health, Education and Welfare Department's budget for health service and health research was only four hundred and forty-five million dollars (fiscal year 1956).

Another symptom of our times is the way in which the split of the medical care dollar is changing.

Both medical practitioners and ethical pharmaceutical manufacturers can be proud of their success in holding down costs.

In 1963 18 cents of the health care dollar went for drugs and sundries. Actually, only 11 cents of this was for prescription drugs, 4 cents being spent for proprietary remedies, and 3 cents for sundries. In 1943 drug and sundries accounted for 24 cents out of every health dollar.

Patient expenditures for prescription and over-the-counter remedies promoted to physicians from all dispensing outlets amounted to about $12.99 per year at the manufacturer's selling price, or about $20.00 per capita at retail prices.

Wholesale drug prices were down again in January of this year from December of last year, as a result of which they are down 1.8 per cent from a year ago. In fact, the Wholesale Price Index for drugs in January was 94.5 (January, 1961, being used as 100).

This is dramatic evidence, I believe, of the drug industry's effort to provide people in the U.S.A. with drugs at reasonable prices.

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† *An edited version of a talk presented by Doctor Smith at the 1965 KMA Interim Meeting in Owensboro March 18, 1965.*

**Then president of the Pharmaceutical Manufacturer's Association; recently named vice-chairman of the Board of Directors of Parke-Davis Company, Detroit.*

Well, how did the doctors do? In 1963, physicians received 25 cents of every health care dollar. Twenty years earlier, they received 26 cents.

The practicing physician's assets are his knowledge and his time. Frankly, I marvel that his magnificent contribution to the health and welfare of the people costs four per cent less today, proportionately, than it did 20 years ago. Of course I admit that the total expenditures for physicians' care and drugs are more today than over preceding years, but so are the total expenditures for other things such as rent, cars, food, clothing and entertainment. But when one looks honestly at the expanding population, the increase in available dollars, the improved quality of goods and service, one would expect greater total expenditures. Thus it's the per cent of the available dollar spent that is important in the assessment of what the true cost is for the individual.

Let me turn from socio-economic problems to a few thoughts about trends in the practice of medicine itself.

Trends in Medical Practice

I know that no one will misunderstand if I observe that medical science has overcome, as major public health problems, many of the diseases that used to cost countless lives and cause much suffering in the grade school and high school populations and among the young adults who make up the heart of the country's labor force. Their health problems are increasingly under control with widespread availability of highly effective biologicals, anti-bacterials and other therapeutic agents, along with the other scientific contributions which are change in emphasis on medical challenges, medical part of medical care.

Today, as a result of expanding knowledge and science is more concerned with safeguarding the fetus, the newborn and the oldster. So, we become interested, for example, in prevention of prenatal injury, and prevention of disease in the very young and in the old.

I know that you in medicine, like we in the pharmaceutical sciences, are determined to meet and surmount the challenges on these promising frontiers of research and medical practice.

The federal government, I suggest, should regard itself as a source of appropriate regulation and of helpful interest in advancing the public health and welfare. But it should also keep in mind the effect of today's regulatory or legislative actions on our people's future. Government and people alike should ask themselves 'How will our record appear in the years ahead? Will we look back with shame or with pride'?

An emphatic warning here: Neither government nor people should look to the systems of other nations for solutions to our problems. No system of government has worked as well with a population like ours as has our own. We should take pride in the American system and strive to preserve it. The changes that are indicated should be made with evolution, not revolution, in mind. We should try to add to the welfare of the body as a whole, not try to redesign it. Few other societies in today's world are like ours, and their methods will not necessarily solve our problems.

So the doctor, the scientist, the nurse, all the professionals in the health team, must think in terms of working together to attack and conquer disease. But they must do so within the changing framework established by our society. Sometimes the views of society can be a great stimulus to progress. At other times, they can be a barrier. We must use our resources to insure they are the former.

One clear view our society already holds is that protection of the health is a social obligation. American society no longer regards acceptance of health care financed with public funds as a "handout." This creates a heavy social responsibility for all of us if the national interest is to be advanced along with the public health.

As I view it, the drug industry does not have a social responsibility of giving away its products or of making them available without profit if it is to stay in business and discover and produce. And yet its members do this daily when physicians inform them of special needs, when government agencies or other bodies seek certain drugs, and when there are requests for service items, that is, items that cost so much to produce and are used so rarely that they cannot be priced even at cost.

In addition, the industry gives away each year millions of dollars in goods, as well as money, for other charitable purposes. But this is not a compulsory policy for the industry. The industry does this because under a private enterprise system concept it has been able to discover, to promote, to sell, and to make a profit for its investors, for expansion when new factories are needed and for giving as the purse strings permit.

On the other hand, it is the industry's responsibility, as I view it, to survive and to discover new drugs. This is a responsibility to society. It can only do this when there is incentive for those who are willing to risk money for investment, time for management, and skills for research and production.

Some may say drug prices are too high and company profits are too great. As I have said repeatedly, I do not know what is too high or too much for any article. I can determine, however, if I think I am getting my money's worth.

For drugs, in general, I think I am, particularly when I contemplate that advancing medical science has saved seven times as many lives since 1944 as were snuffed out in this country during three wars, World War I, World War II, and the Korean War.

As for profit, there is nothing secret about the motivation. A professional man hopes to make sufficient money for business and personal needs and for some comforts and luxuries for his family. So does the non-professionally trained person. So does business, but instead of comfort and luxuries it is seeking encouragement from investors, it is looking for new products to justify its continued existence, and it is trying to cope increasingly with competition from other countries. There is nothing wrong with profits or bank accounts. These are not dirty

words. On the contrary, they are part of the vocabulary that made possible this government. They make possible the two billion plus budget for H.E.W. and they are what our competitors from foreign shores have had in mind, now have in mind, and will continue to have in mind. So why shouldn't we remember these incentives that have guided man since his days in the caves. I don't care, personally, how much profit a man makes in a compeitive market. I am much more interested in what he does with it, just as I am interested in what the professional man or the successful newspaper, or anyone else does to provide leadership and offer contributions. This cannot be done with wishful thinking alone.

Some people say there are too many drugs and there is too much molecule manipulation. As long as the free flow of the forces of competition is permitted, as long as there are unpredictable variations in the human body and as long as there are unmet medical needs, there must be molecule manipulation.

Names and Patents

The Pharmaceutical Manufacturers Association is not opposed to the use of generic names or in favor of only using trade names. In fact, the law requires, and has for many years, inclusion of the generic (or common or usual) name on all prescription drug labels. What it is in favor of is free choice for the physician who not only must learn the individual needs of his patients but also the often encountered unique properties of certain drugs, drug combinations and dosage forms that he learns through experience to use well.

The pharmaceutical industry does not want any special privileges concerning the use of names any more than it seeks special privileges in other areas, but it does ask to be treated equally. In spirit, copyrights are used the same way except they give protection, whereas trade names are intended to promote confidence as well as identification.

Patents have been shown to be the source of great contributions to an industry and the people it serves.

The drug industry has used patents repeatedly as an incentive in a way that has brought relief from suffering and death, has added to the economy of this country and has provided leadership for the U.S. in other countries.

Yet there are some in this country who are willing to see the patent system broken as far as the drug industry is concerned and who, in fact, abet this by encouraging trespassing on the rights of others. Some refer to the act of ignoring patent rights as pirating, and others say it is a form of stealing.

How discouraging it is, then, to watch certain agencies in our own government participate in the encouragement of this trespassing on the rights of others when they buy drug products from other countries that are made in violation of patent rights. Surely these government offices would protest if someone deliberately helped themselves to special equipment built specially for their own offices.

One of the newer aspects of professional and business life is the growing interest—of necessity—in legislative and regulatory matters. Medicare, Eldercare, legislation to control movement of barbiturates and amphetamines, and many other subjects of national interest are now part of our everyday conversation. And they have to be. Otherwise we are shirking our responsibilities as allegedly informed experts and as good citizens.

If an industry or a profession is to put into practical application with fullest possible benefits its skill or art, it must be able to share with possible recipients or users information about itself and what it can do. However, once the facts are obtained and disseminated, others should learn their significance. If one makes a worthwhile drug, for example, its usefulness is determined by the *medically competent* person who prescribes it, the user who follows instructions, and the government when it adopts guidelines for safety or places limitations on availability and use.

Of allied importance is the press, which may influence dramatically the thinking and action of the sick person and of the government legislator or regulator. Over the past few years, those who are responsible for the development and administration of drugs have observed repeatedly the effects of misleading headlines, misuse of facts, careless writing, and unfounded charges and insinuations by individuals in prominently located offices. This is most unfortunate when there already is fear and uncertainty among the sick because of their suffering.

There is so much available for those who need health services and health products. To cause them to be deprived of any part of those benefits by engendering confusion, uncertainty and doubt is most regrettable.

A long time ago, Bacon wrote: "There are three parts in truth: first, the inquiry, which is the wooing of it; secondly, the knowledge of it, which is the presence of it; and thirdly, the belief, which is the enjoyment of it."

Perhaps in the health field there is a responsibility for all to seek the truth while the pharmaceutical industry is seeking new cures. For it will be through revelation of the truth that man will be able to best benefit from scientific knowledge. Truth, then, becomes a social responsibility for all of us.



Health Cares Weaken

THE CITY Board of Health recently announced that the School of Nursing at the Louisville General Hospital will be closed, that the present classes will continue to receive instruction until graduation but that no new students will be accepted. The reasons offered were that it costs the city $140,000.00 annually to run the Nursing School and far below its normal capacity; only 13 nurses graduated there last year and few remained to render nursing service in the hospital for which the School was primarily established.

These reasons seem logical and more or less compelling; however, serious thought should be given the matter before closing one of the oldest and best nursing schools in the state at a time when a shortage of trained nurses has reached a local and national crisis. This school was established in 1889. It has perhaps educated more nurses than any other school in Kentucky and because of its close affiliation with the University Medical School it seems reasonably justified in its claim to offer the best nursing education of any other institution in the state. Quite justifiably the alumnae and many of their friends and local physicians have challenged the propriety of the City Board of Health's decision.

If the Nursing School at the General Hospital closes it will be the third school of nursing in Louisville to cease operation during the past 20 years, and during this period no new one has been established. A rather forlorn prospect is offered of establishing a combined School of Nursing in which the General Hospital, Children's Hospital, Jewish Hospital, and the Methodist Evangelical Hospital will cooperate in training nurses. This plan has been discussed for about ten years, but seems no nearer achievement now than it was that long ago.

The nursing care of the seriously ill patient has deteriorated remarkably during the past two decades, simply because the supply of adequately trained nurses has in no respect kept pace with the rapid increase in the number of hospital patients. Every general hospital in the state as well as specialized hospitals, nursing homes, and the public health service has suffered increasingly from shortage of trained nurses and has had to substitute care for the patient by less adequately trained licensed practical nurses and aides. The new hospital at the University of Kentucky is not yet operating at full capacity because they have not been able to adequately staff the hospital with well trained nurses.

It is stated that there are 840 nursing schools in the United States offering the R.N. degree and these produce about 80 per cent of the trained nurses in this country. The American Nurses Association has undertaken to raise its sights so far as nursing education is concerned and has expressed a preference for a Bachelor's Degree in nursing that would be attainable after a four year college course in which practical nursing is a part of the training. About 15 per cent of today's nursing students are in this type of program. A more recent plan has been the offering of a two-year course combined with Junior College training after which the graduate may obtain the degree by examination. It is estimated that about five per cent of the girls in training are participating in this type of course.

A few years ago when the shortage of physicians was most acute there arose a great impetus to provide shorter and less complete courses in medicine so that there would be a greater number, although less adequately trained, physicians to fill less desirable locations where medical care was so urgently

needed. Fortunately this concept received no substantial support and the matter of medical education has been maintained on an uncompromising level of excellence. It is correctly the philosophy that an ill patient, whether he be in a neglected rural area or a populous urban community, needs the best medical skill that our present knowledge can provide.

It would appear to us that the nursing situation is parallel. We need no compromise in the thoroughness of the training of the nurse who is to care for the seriously ill, but we do need more adequately trained nurses. The proportion of 80 or 85 per cent trained for practical bedside nursing and 15 per cent better prepared for teaching and the executive operation of the profession seems approximately correct.

The Nurse's Training Act of 1964 provided that the Federal Government set apart about $287,000,000.00 for a program of construction, grants, teaching, subsidies and scholarships to strengthen and expand the education of professional nurses with a provision for loans to nursing students who cannot otherwise finance their education. This program is already in operation in some states. It would be more widely used if more of our hospitals had the courage and vision to incorporate expanded nursing training plans in the enlargement of their facilities, or in establishing new schools of nursing to meet our growing crisis.

It will be said that the present schools of nursing generally run at less than capacity and why should new schools be established or old ones maintained and enlarged; that suitable applicants for nurses' training are not available. Nursing is a service profession that has commanded the respect and admiration of all during the past half century. It is not without glamour nor the rewards of gratitude, satisfaction and prestige that are enjoyed by the members of other learned professions. Perhaps a vigorous campaign of recruitment for student nurses would be as effective as has a similar campaign for the recruitment of medical students during the past 20 years. There are many girls in high school who would look forward to such a career with anticipation and eagerness if they were but adequately informed. Of course, the intelligent, attractive and alert young girl who is fitted for nurse's training is not likely to devote her entire time to that profession for very long, but it would be better to have her in the profession for what time she can give to it before she is married and has a family and what service she may offer to her profession in the years beyond this period than to be without her interest and service at all.

There is one other factor that deserves consideration. Mrs. Pat Dressler, R.N., of Louisville, wrote in the Point of View Column of the Louisville Times, February 5th:

> I would like to pick up the newspaper just one time and not have to read about the poor teachers and how underpaid they are in the state of Kentucky.
>
> Don't misunderstand me, teachers' salaries are low, but what about the registered nurses of this state? No one, not even the governor, is worrying about our salaries.
>
> Fourteen years ago in California I started general duty in a hospital for the same amount of money I am working for in this state today. That is one reason there is such a shortage of nurses today. Many have gone into other work for better salaries and working conditions.
>
> We don't get three months off in the summer time, every holiday and week-end off. We also work around the clock. What would happen if every registered nurse in Kentucky would not show up for work in a 24-hour period? We wouldn't dare.

This same facet of our nurses' shortage is brought out in a survey and an editorial by Doctor Morris Fishbein in the January 28 issue of *Medical World News*. It is our impression that Mrs. Dressler has a point—that the members of her profession are underpaid in comparison with the cost of other less important services of today.

One-hundred-forty-thousand dollars a year is a disproportionate cost for the education of 13 graduate nurses—but there should be a better solution than to close the school. It could be up-graded and made more attractive to prospective students—the physical facilities, working conditions and salaries could be improved and with a vigorous recruitment program train fifty nurses a year. In this time of increasing responsibility for good medical care we dare not go backward—but forward.

SAM A. OVERSTREET, M.D.

ORGANIZATION SECTION



Springtime in the Kentucky mountains will be an attraction for the entire family during the 1966 KMA Interim Meeting at Cumberland Falls State Park, April 13 and 14. DuPont Lodge, above, will house meetings of the KMA Board of Trustees, and the Board of the Woman's Auxiliary to KMA, as well as regular sessions of the meeting. Adequate housing has been arranged for all. The Interim Meeting this year is scheduled to coincide with the meeting of the KEA.

Utilization Review, Prepayment Plans, Medicare Operation Among Topics Of Guest Authorities at 1966 KMA Interim Meeting April 13-14

Top representatives of medicine, labor, the federal government and related interests will discuss current socio-economic problems facing the medical profession in 1966 at the KMA Interim Meeting April 13 and 14 at Cumberland Falls, Everett H. Baker, M.D., KMA president, has announced.

Doctor Baker, who released the complete program, said that guest speakers will cover both broad and specific aspects of the operation of Public Law 89-97, which will go into effect July 1, labor's view on voluntary prepayment plans, and the objectives of the Appalachian Regional Commission now operating in Eastern Kentucky.

"The Role of Medicine in 1966" is the theme of the conference, and will also be the subject of a speech by James Z. Appel, M.D., American Medical Association president from Lancaster, Pa.* Doctor Appel will speak at the Thursday luncheon.

"Utilization Review Under PL 89-97", a panel discussion, will open the meeting on Wednesday evening. Participating will be representatives of the American Medical Association's Council on Medical Services, the Social Security Administration, a former president of the Kentucky Hospital Association, and executive of Blue Cross Blue Shield Plans of Kentucky.

"Voluntary Prepayment Plans as Viewed by Labor" will be discussed on Thursday morning by John E. Sparks, program consultant in the Social Security Department of the United Automobile Workers Union. Mr. Sparks is responsible for the guidance and development of health benefits and insurance programs for UAW members and their families.



Doctor Appel

A graduate of the School of Social Service Administration, Chicago, Mr. Sparks spent 12 years in charge of the Health Services Planning Unit with the department of National Health and Welfare, Ottawa, Canada, during which time he helped develop the Canadian hospital insurance program. For three years he served as a deputy minister of public health for Ontario.

Philip R. Lee, M.D., assistant secretary for Health and Scientific Affairs in the U.S. Department of Health Education and Welfare, will then discuss "Operational High Points of PL 89-97". Doctor Lee formerly served as director of Health Services for the

Additional background information on Doctor Appel was published in the December 1965 issue of The Journal, page 1028.



Doctor Slagle

Program

KMA 1966 Interim Meeting

DuPont Lodge, Cumberland Falls

April 13 and 14, 1966



Doctor Lee

WEDNESDAY EVENING SESSION

Everett H. Baker, M.D., Louisville, President,
Kentucky Medical Association, Presiding

5:00* **Registration**

6:30 **Dinner,** Main Dining Room

Invocation—Henry B. Asman, M.D., Louisville, KMA Secretary

7:30 **Call to Order,** Doctor Baker

7:40 **Panel Discussion: "Utilization Review Under PL 89-97"**
Doctor Baker, Moderator

As Seen By:
The Social Security Administration: Philip R. Lee, M.D., Washington, D.C.
The Hospital: Mr. Wade Mountz, Louisville
Blue Cross and Blue Shield: Mr. Avil McKinney, Louisville
Medicine: George W. Slagle, M.D., Battle Creek, Mich.

Question and Answer Session —The audience is requested to submit written questions

THURSDAY MORNING SESSION

Doctor Baker Presiding

8:00 **Registration**

9:10 **Call to Order,** in the Lounge

9:15 **"Voluntary Prepayment Plans as Viewed by Labor"** —Mr. John E. Sparks, Detroit, Mich.

9:45 **"Operational High Points-PL 89-97"** —Philip R. Lee, M.D., Washington, D.C.

10:15 **Coffee Break**

10:30 **"Objectives of the Appalachian Regional Commission"**—Mr. Ralph R. Widner, Washington, D. C.

10:50 **"Health Objectives of the Appalachian Regional Commission"**—Robert R. Huntley, M.D., Chapel Hill, N.C.

11:10 **Question and Answer Session** —The audience is requested to submit written questions

LUNCHEON SESSION

12:30 p.m.
Robert E. Pennington, M.D., London, President-elect
Kentucky Medical Association, Presiding

Invocation —Reverend R. Haskel Bolding, Pastor, First Baptist Church, Corbin

"The Role of Medicine in 1966" —James Z. Appel, M.D., Lancaster, Pa.

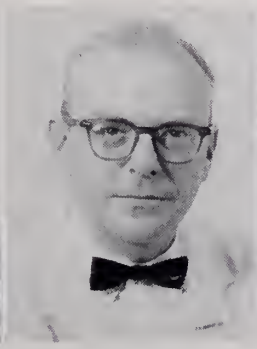
**All times listed Eastern Standard Time*



Mr. McKinney



Mr. Widner



Doctor Huntley



Mr. Mountz



Mr. Sparks

Agency for International Development (AID) in the Office of Technical Cooperation and Research.

Another highlight of the Thursday program will be a discussion of the activities of the Appalachian Regional Commission. Robert R. Huntley, M.D., Chapel Hill, N.C., director of the Commission's Health Advisory Committee staff, will present the medical objectives of the Commission. Ralph R. Widner, Washington, D.C., will give a brief talk on its purposes.

Mr. Widner has been executive director of the Commission since June 1965. He was formerly assistant director of the Pennsylvania State Planning Board and has also served as director of Public Affairs for the Pennsylvania Department of Forests and Waters.

Kentuckians appearing on the meeting program will be Avil McKinney, Louisville, director of Professional and Public Relations for Blue Cross-Blue Shield, and Wade Mountz, Louisville, administrator of Norton Memorial Infirmary and former president of the Kentucky Hospital Association.

In discussing the program, KMA President Baker remarked, "We believe we have put together a timely, informative conference which will be of great interest and benefit to physicians in this state. This year marks the beginning of a new era in medicine, and Kentucky doctors are urged to examine their role in its development. The Interim Meeting provides an excellent opportunity to do so."

DuPont Lodge at Cumberland Falls will provide facilities for the conference, as well as the meeting of the KMA Board of Trustees beginning at 9:00 a.m. Wednesday, April 13. The Woman's Auxiliary to KMA will also hold its Board meeting on Wednesday.

Please Make Your Reservations Soon for Interim Meeting

You are urged by KMA president Everett H. Baker, M.D., Louisville, to make your room or cottage reservations as soon as possible for the KMA Interim Meeting at DuPont Lodge, Cumberland Falls, on April 13 and 14.

Free lines to the Central Park Bureau in Frankfort may be used for residents of certain areas in making reservations. These are: Louisville—583-9796; Lexington — 252-4913; and Covington and the Cincinnati area—261-2643.

If you telephone the Lodge directly, the number is 528-4121 (Area Code 6061. In making reservations, *Please be sure to indicate that you are attending the KMA Interim Meeting*, Doctor Baker said. Otherwise you may be told that the Lodge is sold out.

After rooms and cottages at DuPont Lodge have been filled, overflow reservations will be referred to one of two modern and convenient motels located near the park, approximately one-and-a-half miles west of the Cumberland River. The two are the Holiday Motor Lodge and the Falls Motel.

New Member Orientation Course Scheduled for April 13

The second KMA Orientation Course for new members will be held April 13 at DuPont Lodge, Cumberland Falls, just prior to the opening of the 1966 KMA Interim Meeting. The first course was held at the Annual Meeting last Fall.

The program, approved by the KMA House of Delegates, is designed to better equip the new KMA member in meeting present-day responsibilities as a citizen and a physician. The session will begin with registration at 12:30 p.m.

Each new member who has not previously attended the Orientation Course will be sent letters of invitation. New members are required to attend such a meeting and are given two years from the date of joining the Association to do so. Two sessions are planned for each year, one at the Interim Meeting and one at the Annual Meeting.

Dr. Brockman to Give Slide Talk On Vietnam at Interim Meeting

A special highlight of the KMA Interim Meeting this year will be a slide-illustrated talk on South Vietnam by George F. Brockman, M.D., Greenville, who recently returned from a two-month tour as a volunteer physician in that country under the auspices of Project Vietnam.

The American Medical Association is cooperating in this program, which sends teams of American physicians to South Vietnam to provide medical care to Vietnamese civilians in hospitals operated by the Agency for International Development (AID).

The slide presentation will be made to KMA members, their wives and guests following the opening panel discussion at the Interim Meeting on Wednesday evening, April 13. The photographs illustrate everyday medical, military, and civilian life in a country divided by war.

Doctor Brockman, who was one of the first volunteers for the Project Vietnam program, spent October and November of 1965 in that country. He is speaker of the KMA House of Delegates and was chairman of the KMA Building Committee.

Lexington Clinic Plans Program

J. G. Rushton, M.D., consultant in neurology at the Mayo Clinic, will be the featured speaker at the Eleventh Annual Lexington Clinic Conference planned for March 31 at the Clinic. His topic will be "Treatment of Convulsive Disorders."

A series of presentations on convulsions will make up the morning program, which begins with registration at 8:30 a.m. The afternoon session will offer five talks on diversified topics such as "Conception Control" and "Chemotherapy in Malignancy." Additional information may be found in the February issue of *The Journal.*





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Effective in a wide range of everyday infections —respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Warning — In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncracy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

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Metropolitan Life Insurance Co. Named Ky. Medicare Carrier

The Metropolitan Life Insurance Company of New York has been appointed "carrier" for Kentucky by the Social Security Administration to administer Part B. Title XVIII of Public Law 89-97, according to R.M. Ball, Washington, Social Security administrator.

The special ad hoc Committee of the KMA Board of Trustees, which has been assigned the duty of studying Title XVIII and advising the Board on its implementation planned a meeting on March 9 with appropriate officials of Metropolitan.

According to Mr. Ball's announcement, 32 Blue Shield plans and 15 insurance companies have been appointed carriers for 49 of the states. The carriers for one state and three possessions have not been announced.

The Board of Trustees of KMA early in December had nominated the Kentucky Blue Shield Plan as the carrier for Kentucky.

Dr. Denham in 11 Committee Posts In Ky. House of Representatives

Mitchel B. Denham, M.D., Maysville, representative from District 70 (Bracken and Mason Counties) is one of the busier men in the Kentucky Legislature's House of Representatives this year.



Doctor Denham

In addition to being speaker-pro-tem of the House, Doctor Denham is serving in various capacities on the following 11 committees of the House: Agriculture; Appropriations; Drainage and Water Districts; Insurance; Kentucky Statutes No. 1; Kentucky Statutes No. 3: Legislative Affairs; Public Health; Public Utilities; Ways and Means; and Roads and Highways.

Doctor Denham is serving as trustee from the Ninth Trustee District on the KMA Board of Trustees and has long been active in local civic and medical affairs.

Nominating, Awards Committees To Meet at Interim Meeting

The KMA Nominating and Awards Committees will meet at well-marked tables during the Thursday, April 14 luncheon session of the Interim Meeting at Cumberland Falls, so that members may visit with each committee to present their nominations for general officers and awards recipients.

Each committee will present slates of nominees during the KMA Annual Meeting in September. The Nominating Committee is composed of Harold B. Barton, M.D., Corbin; Ballard W. Cassady, M.D., Pikeville; Irving F. Kanner, M.D., Lexington; W. Vinson Pierce, M.D., Covington; and William T. Rumage, Jr., M.D., Louisville. A chairman will be chosen at the luncheon meeting.

The Awards Committee, headed by William H. Bizot, M.D., Louisville, also includes Richard Grise, M.D., Bowling Green; James M. Keeton, M.D., Ashland; Joseph Keith Jr., M.D., Lexington; and Max D. Klein, M.D., Shelbyville. The committee will make nominations for recipients of the Distinguished Service, Outstanding General Practitioner, and R. Haynes Barr awards.



Doctor Howard



Doctor Coleman

Critical Dimension to be Topic At Fifth District, JCMS Meeting

"The Critical Dimension", a study of the past, present and future of medicine, will be explored April 18 at the joint meeting of the Fifth KMA Trustee District and the Jefferson County Medical Society, according to Alfred O. Miller, M.D., district trustee, and Hoyt D. Gardner, M.D., JCMS president.

Ernest B. Howard, M.D., executive vice-president of the American Medical Association, and Frank C. Coleman, M.D., Tampa, Fla., chairman of the Board of the American Medical Political Action Committee, will discuss the scientific, economic, legislative and political accomplishments of medicine and its hopes for the future.

Doctor Howard, who has made several speaking appearances in Kentucky, has been an executive officer of the AMA since 1948. In that position he headed the AMA's task force in resisting medical care legislation. He is a graduate of the Boston University School of Medicine.

Doctor Coleman, a pathologist, has been a member of the AMPAC Board for many years. He is a member of the AMA Council on Legislative Activities and of the Study Committee on Pathology. A native of Mississippi, he is a graduate of Tulane University School of Medicine. He formerly practiced at Des Moines, Ia.

Physicians and their wives from all over Kentucky will be invited to attend the meeting, which will also feature remarks by representatives of KMA. A social hour will begin at 6:00 p.m., dinner at 7:00, and the meeting at 8:00 at the Executive Inn in Louisville.

REMEMBER VOTER REGISTRATION

March 26 is the last date prospective voters in Kentucky may register to vote in the May primary elections, which will be held on the 24th of that month. If you have recently moved into the state, or have moved from one city to another, it is important that your registration be changed accordingly so that you may exercise your right to vote. This year's primary in Kentucky involves one U.S. Senate seat, seven U.S. representatives, and some local offices.

Thirteenth Trustee District To Meet April 5, Ashland

The Thirteenth KMA Trustee District will meet jointly with the Boyd County Medical Society on April 5 at Ashland, according to Walter L. Cawood, M.D., Ashland, district trustee.

A social hour will begin at 6:30, with dinner at 7:00, followed by the meeting, Doctor Cawood announced. Wives will be invited to attend.

Final plans for speakers have not been made at the time of this writing. Individual invitations will be sent to members of the trustee district.

AMA Sends Dr. Long to Vietnam To Study Health Facilities

Robert C. Long, M.D., Louisville, a member of the American Medical Association's Board of Trustees, recently returned from a trip to South Vietnam to study the feasibility of expanding medical facilities in that country.

Doctor Long headed a four-man team representing the AMA Board, who conducted the investigation at the request of the U.S. Agency for International Development (AID). The inspection was instigated by the government of South Vietnam, who asked the U.S. Government to make the study.

Accompanying Doctor Long on the tour were Ernest B. Howard, M.D., executive vice-president of the AMA; Walter S. Wiggins, M.D., secretary of the AMA Council on Medical Education; and William A. Sodeman, M.D., a member of the Council and dean of Jefferson Medical College, Philadelphia.

The Federal government asked the AMA to focus special attention on the medical school in Saigon, and to consider the expansion of its training program with a view toward supplying the country with additional medical personnel. U.S. assistance would include supplying medical educators trained in this country and medical consultants for existing facilities. Recommendations from the study team will go to the AMA Board of Trustees, who will consider them and pass them on to the U.S. government.

Drs. Baker, Greathouse, Speak At Seventh District Meeting

"The Physician in 1966" was the topic of Everett H. Baker, M.D., KMA president from Louisville, the featured speaker at the Seventh KMA Trustee District February 23 at Shelbyville, according to Donald Chatham, M.D., Shelbyville, trustee for the district.

Richard F. Greathouse, M.D., vice-speaker of the KMA House of Delegates and secretary of the Kentucky Educational Medical Political Action Committee also addressed the assembly on "KEMPAC's Opportunities in 1966."

The meeting was held at Science Hill Restaurant. Wives attending the dinner meeting were treated to a tour of the historic building, formerly a girl's school, and an adjacent antiques gallery, Doctor Chatham said.

Eighth District Meeting Planned April 7 at So. Ft. Mitchell

Everett H. Baker, M.D., Louisville, and Carl Cooper, M.D., Bedford, will be the principal speakers on the program of the Eighth Trustee District Meeting April 7 at South Fort Mitchell, W. Donald Janney, M.D., Covington, district trustee, has announced.

Doctor Baker will discuss the role of the physician in 1966, and Doctor Cooper will address the group on the achievements and goals of the Kentucky Educational Medical Political Action Committee.

Wives of members will be invited to attend the meeting, which will be held at the Lookout House, Doctor Janney said. Members will be sent individual invitations.

Governor's Occupational Health Conference to be March 28

The second annual Governor's Conference on March 28 in Louisville will have its theme "The Supervisor's Role in Occupational Health and Safety," according to Gradie R. Rowntree, M.D., Louisville, conference chairman.

In conjunction with the conference, which is to be held at the Brown Hotel, the Occupational Health Section of the Kentucky Nursing Association will meet March 26, and the Kentucky Industrial Medical Association on March 27, both at the Brown.

John E. Eckerle, M.D., president of the Industrial Medical group and program chairman for the conference, said that pre-conference consultants on such topics as medicine, safety, toxicology, nursing and labor will be available to early arrivals at 7:00 p.m., Sunday, March 27. Films on other subjects will also be shown at that time.

Edward T. Breathitt, Governor of Kentucky, will address the group at 10:00 a.m. Monday. Other speakers will present such topics as "Environmental Health Hazards," "The Industrial Hygienist on the Health and Safety Team," and "Job Disruption Concept with Focus on Accidents." Group workshop subjects will include: "Occupational Health in the Community," and "Motivating People in Health and Safety."

Last year's conference, the first of its kind in Kentucky, was held in Lexington and attended by approximately 250 people.

YOUR SECRETARY NEEDS YOUR DUES

"If you have not already paid your county, state, and AMA dues, please assist your county society secretary by doing so as soon as possible," requests KMA president Everett H. Baker, M.D. He continued, "Like you, your secretary is a busy man, and would appreciate your helping him to avoid a last-minute rush." Bylaws provide that dues remaining unpaid by April 1 be considered delinquent.

KDA Plans 106th Annual Meeting For April 3-6 in Louisville

William K. Keller, M.D., professor and chairman of the department of psychiatry at the University of Louisville School of Medicine, will be a featured speaker during the Kentucky Dental Association's 106th Annual Meeting April 3-6 in Louisville.

Doctor Keller was invited to participate as this year's exchange speaker from the Kentucky Medical Association. His topic has not yet been announced.

The theme of the meeting, which will be conducted at the Brown Hotel, will be "Preventive Dentistry", according to A. B. Coxwell, D.M.D., executive secretary of KDA, who released the program information.

Among the topics to be presented during the four half-day sessions will be: "The Office Application of a Preventive Dentistry Program", "Epidemiologic Aspects of Periodontal Disease", "Malocclusial Relationships", and "Helpful Hints in Preventive Dentistry".

UN Correspondent to be Speaker At Hospital Assn. Session

Miss Pauline Frederick, United Nations correspondent for NBC radio and television, will speak at the April 26 President's Luncheon held by the Kentucky Hospital Association during its annual meeting in Louisville April 25-28, according to W. Leon Hisle, Berea, KHA president.

Four physicians and a number of other speakers will share the spotlight with Miss Frederick during the four-day session at the Kentucky Hotel, and will take part in panel discussions on various topics.

They are: Madison B. Brown, M.D., associate director of the American Hospital Association; Robert Q. Marston, M.D., a vice-chancellor and dean at the University of Mississippi; William H. McBeath, M.D., Frankfort, director of the Bureau of Medical Services in the Kentucky Department of Health; and Robert C. Tate, M.D., Louisville surgeon.

Fifteen allied organizations will meet concurrently during the convention, for which registration is expected to exceed 1,700.

Ky. Ob-Gyn Society Meeting Set April 14-16 in Cincinnati

Five distinguished guest speakers will discuss problems connected with obstetrics and gynecology at the 19th Annual Meetings of the Kentucky Obstetrical and Gynecological Society April 14-16 at the Netherland Hilton Hotel in Cincinnati, Society President Elwood L. Woolsey, M.D., Harlan, has announced.

Appearing on April 14 morning program will be Frederick P. Zuspan, M.D., professor and chairman of the department of obstetrics and gynecology at the Medical College of Georgia. Richard D. Bryant, M.D., clinical professor of obstetrics at the University of Cincinnati, will take part, with Doctor Zuspan, in a panel discussion during the same session.

Nichols Vorys, M.D., assistant professor in the department of obstetrics and gynecology at the Ohio State University College of Medicine, will be the first speaker Friday morning. Raymond C. Mellinger, M.D., of the section of endocrinology at Henry Ford Hospital, Detroit, will present two papers on Friday morning.

Also participating in the session will be Alan Rubin, M.D., director of the Office of Health Survey of the department of obstetrics and gynecology at the University of Pennsylvania. Other speakers will be members of the departments of obstetrics and gynecology at the University of Louisville and the University of Kentucky.

Doctor Woolsey said that features of the meeting will include the election and installation of officers, and the presentation of prizes for the two best papers submitted by obstetrical and gynecological residents.

The meeting will close Saturday morning following an open meeting of the Kentucky Medical Association's Committee on Maternal Mortality. Members of the Cincinnati Obstetrical and Gynecological Society, interested physicians from the area, and residents, interns and medical students are invited.

KAGP May Scientific Assembly Features Ten Top Lecturers

The Kentucky Academy of General Practice will hold its annual Scientific Assembly on May 11, 12, and 13 at the Kentucky Hotel in Louisville, Carroll L. Witten, M.D., Louisville, KAGP president, has announced.

Featured on this year's program will be ten outstanding guest speakers, four of whom are former Louisvillians, Clarence E. Quaife, M.D., Louisville, program chairman, said.

The four are Arthur H. Keeney, M.D., Philadelphia; Joseph A. Little, M.D., Nashville; Hugh B. Lynn, M.D., Rochester, Minn.; and Richard P. Schmidt, M.D., Gainesville, Fla. Other guests will be Thomas L. Marchioro, M.D., Denver; Richard G. Martin, M.D., Houston; Richard E. Palmer, M.D., Alexandria, Va.; Franklin D. Schwartz, M.D., Chicago; John P. Utz, M.D., Richmond, Va.; and William H. Weidman, M.D., Rochester, Minn.

Doctor Martin's appearance will be sponsored with the cooperation of the Kentucky Cancer Society, and Doctor Utz with the Kentucky Thoracic Society.

Surgical Society Meeting Set

The Kentucky Surgical Society will meet May 14 and 15 at the French Lick (Indiana) Sheraton Hotel, according to an announcement by Rudolf J. Noer, M.D., Louisville, Society president. Doctor Noer said that Angus McLachlin, M.D., of London, Ontario, will address the group on "Sequelae of Venus Thrombosis and their Management". Further information will be published in the April issue of *The Journal.*

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GROUP DYNAMICS. A joint conference on medical Education sponsored by KMA in cooperation with the University of Louisville and the University of Kentucky medical schools was held January 21-23 at Park Mammoth resort. Thirty representatives of KMA and fifteen from each school attended the meeting. Pictured above is a workshop session discussing some of the problems involved in medical education.

Dr. Eiseman Serving in Vietnam As Surgical Consultant

Ben Eiseman, M.D., professor and chairman of the department of surgery at the University of Kentucky College of Medicine, left February 13 for six weeks in Vietnam to serve as surgical consultant to the Navy and to the Marines.

Before leaving, Doctor Eiseman explained that he will have two basic duties: that of consultant to the Marines in the care of battle casualties, and the organization of surgical research projects important in studying casualties in the field.

He will represent the Committee on Trauma of the National Research Council in organizing the Surgical Research Unit. Precedent for such projects was established in the Surgical Research Units in Korea, World War II in Italy, and World War I.

Second Trustee District Holds Jan. 11 Meeting at Owensboro

The civic responsibilities of the physician were discussed by Everett H. Baker, M.D., Louisville, KMA president, who spoke at the meeting of the Second KMA Trustee District January 11 at Owensboro.

Sharing the program with Doctor Baker was Lloyd G. Yopp, M.D., Louisville, who presented a scientific paper on diabetes.

W. Gerald Edds, M.D., Calhoun, trustee for the Second District, arranged the program for the dinner meeting, which was held at Gabe's Restaurant.

KMA Announces New Members

According to the membership department of the Kentucky Medical Association, records show the inclusion of six new members, all from Louisville. This list was current as of February 1.

The six are: Arnold M. Belker, M.D., Fitzhugh Mullins, M.D., Michael Peveler, M.D., M. Saint Pierre, M.D., Bobbie E. Spencer, M.D., and Walter M. Wolfe, M.D.



Doctor Haggai



Doctor Ward

Seniors at Ky's Two Med Schools To Hear Outstanding Speakers

Donovan F. Ward, M.D., Dubuque, Ia., immediate past president of the AMA, and Thomas S. Haggai, D.D., a popular after dinner speaker from High Point, N.C., will be the featured speakers at the respective KMA Senior Day programs at the University of Kentucky and the University of Louisville medical schools, Fred C. Rainey, M.D., Elizabethtown, Senior Day Committee chairman, has announced.

Everett H. Baker, M.D., Louisville, KMA president, and other representatives of KMA will speak on the University of Louisville March 21 program and the University of Kentucky program April 12.

Doctor Haggai, a Baptist minister who averages a speech a day before business, civic, educational and religious groups, will speak on "As a Man Thinketh" to the University of Louisville seniors. He is nationally known for his syndicated radio program, "Values for Living." This twelfth annual program is sponsored by KMA in cooperation with the Jefferson County Medical Society and the School of Medicine.

Doctor Ward, whose topic is, "Be Wisely Selfish," will address the Senior Class at the University of Kentucky at the Third Annual Senior Day program sponsored by KMA in cooperation with the Fayette County Medical Society and the College of Medicine. Doctor Ward has served as an AMA vice president and for nine years was a delegate to AMA from the Iowa Medical Society.

Seniors at both schools will hear talks on the civic and legislative responsibilities of the physician, "Where You Practice," "Human Equation in Medical Practice" and the "Mechanics of Setting Up Practice." Both programs will conclude with a dinner for the seniors.

Pediatricians Plan Joint Meeting

The Kentucky Pediatric Society and the Kentucky Chapter of the American Academy of Pediatrics will hold their annual joint meeting on May 18 and 19 in Owensboro, according to W. D. Bushong, M.D., Owensboro, Society president, who is in charge of arrangements. Additional details will be made available in later issues of *The Journal.*

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Ky. Chapter, ACS, to Meet April 7-9 in Lexington

The Kentucky Chapter, American College of Surgeons, will hold its annual scientific meeting in cooperation with the University of Kentucky department of surgery on April 8 and 9 in Lexington, according to Charles M. Edelen, M.D., Louisville, president.

Ben Eiseman, M.D., professor and chairman of the department of surgery at U. of K., will be in charge of the Friday, April 8, program at the medical center, Doctor Edelen said. Faculty members from the department will present papers at that session. The Saturday session, which ends at noon, will be presented by chapter members and guest speakers at the Imperial House in Lexington.

Doctor Edelen announced that three distinguished guest lecturers will be featured on the program. They are William A. Altemeier, M.D., head of the department of surgery at the University of Cincinnati; J. William Hillman, M.D., chief of orthopedic surgery at Vanderbilt; and C. B. Mueller, M.D., chairman of surgery at the State University of New York Upstate Medical Center at Syracuse.

The chapter's annual business session will be held this year on the evening of April 7 at 8:00 p.m. at the Imperial House. This meeting has been held previously at the end of the scientific program, Doctor Edelen said.

McCracken County Society Hosts KMA First Trustee District

Everett H. Baker, M.D., KMA president from Louisville, was the main speaker at the meeting of the First Trustee District at the Paducah Country Club on January 27, held in conjunction with the meeting of the McCracken County Medical Society.

"Responsibilities of the Physician on the Local Scene" was Doctor Baker's topic. Sharing the program with Doctor Baker was John C. Quertermous, M.D., Murray, legislative key man for the district and KMA delegate to the American Medical Association.

Joseph R. Miller, M.D., Benton, First District trustee, and Walter Johnson, M.D., Paducah, president of the McCracken County Society, cooperated in arranging the program, which included a talk by John Oehlschlaeger, Paducah, president of the Kentucky Pharmaceutical Association.

Medical Assistants to Meet

The Kentucky State Association of Medical Assistants has announced that its annual meeting will be held this year at Stouffer's Louisville Inn on May 14 and 15. Medicare and mental health will be among the topics to be covered on the program, which will include speakers representing the Kentucky Medical Association. Further information will be released later.

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Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

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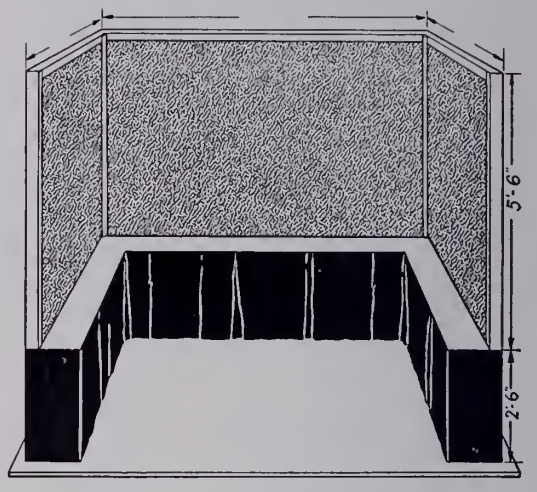
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Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



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2. Name (s) of Exhibitor (s): (AMA Member?) .....

   .....

   Institution (if desired): .....

   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

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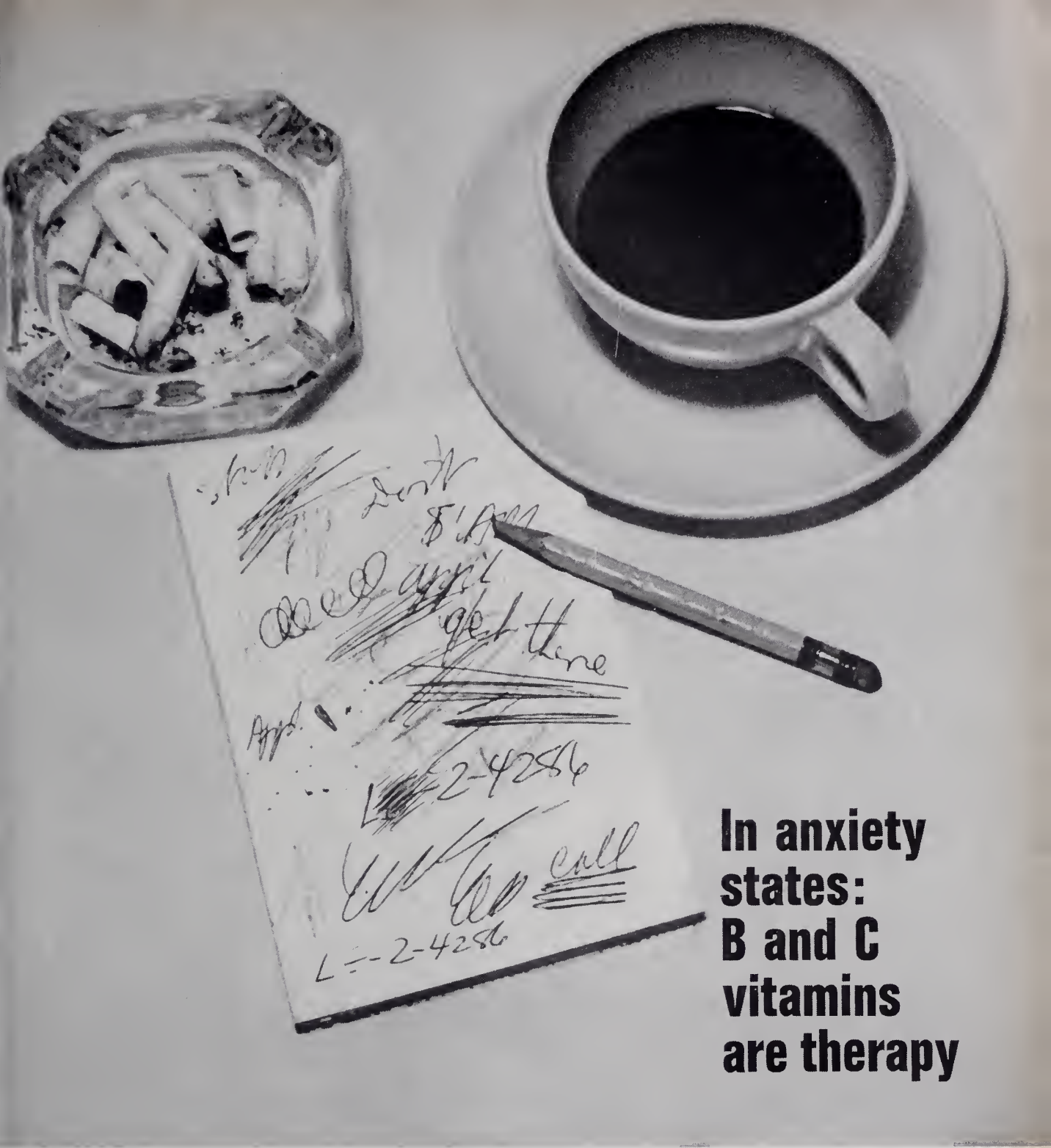
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Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

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Stress formula vitamins are an important supportive measure in maintaining the nutritional status of the emotionally disturbed patient. With STRESSCAPS, B and C vitamins are present in therapeutic amounts to meet increased metabolic demands. Patients with anxiety, and many others undergoing physiologic stress, may benefit from vitamin therapy with STRESSCAPS.

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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Stress Formula Vitamins Lederle

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too young
to be so tired...

revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



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Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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U. of L. Class Reunions Planned During KMA Annual Meeting

Ten five-year classes of the University of Louisville School of Medicine will hold reunions during the KMA Annual Meeting September 20-22, according to Hollis Johnson, M.D., Louisville, president of the U. of L. Medical Alumni Association.

Classes holding reunions this year will be 1916, 1921, 1926, 1931, 1936, 1941, 1946, 1951, 1956, and 1961. Chairmen for these individual class functions have not yet been chosen.

Plans for a general reunion celebration for all alumni and guests are being made. For the past two years this party has been held aboard the Belle of Louisville, but because of other commitments, the boat will not be available. Further information will be printed in *The Journal* as it becomes available.

NEWS ITEMS

Doyle D. Hagg, M.D., has begun general practice at Frankfort after serving with the U.S. Navy. Doctor Hagg, a 1960 graduate of Jefferson Medical College, Philadelphia, interned at the U.S. Naval Hospital in that city.

Mark S. Sexter, M.D., has become associated with **Lytle Atherton, M.D.,** and **L. Douglas Atherton, M.D.** at Louisville, where he will limit his practice to urology. Doctor Sexter was graduated from the University of Louisville School of Medicine in 1957 and interned at the University of Texas Hospital before completing his residency requirements at the University of Louisville.

Arnold M. Belker M.D., Louisville, has opened an office in that city for the practice of urology. A 1958 graduate of U. of L. School of Medicine, he interned at New England Center Hospital at Boston. Following a year of residency at Louisville General Hospital, Doctor Belker completed his training at the State University of Iowa Hospital in 1965.

John B. Williams, M.D., Louisville, has been awarded a $3,500 Christmas Seal grant by the American Thoracic Society to continue work with the pulmonary disease section of the University of Louisville School of Medicine. Doctor Williams is a second year resident at Louisville General Hospital.

Giles L. Stephens, M.D., Louisville, has recently been appointed director of surgical training at St. Joseph Infirmary in Louisville. In another appointment announced at the same time, Doctor Stephens was made director of the cancer clinic at the same hospital.

Virginia Wallace Lewis, M.D., Irvine, has accepted the post of director of health departments in Madison and Rockcastle counties, it was recently announced. **R. R. Snowden, M.D.,** formerly health officer for Madison and Clark Counties, as well as Estill County, has given up the former posts and will serve as part-time head of the Estill County Health Department.

William L. McLeod, M.D., Paris, has recently opened an office in that city, where he will be engaged in general and industrial medical practice. Doctor McLeod is a 1938 graduate of Temple University School of Medicine and interned at Winston-Salem, N.C. He previously practiced at Norwood, N.C.

C. E. Hernandez, M.D., Hardin County health officer since 1961, has been appointed director of the recently-created division of Epidemiology of the Kentucky State Department of Health, announced **Russell E. Teague, M.D.,** state health commissioner. Doctor Hernandez assumed his post February 15.

Austin Smith, M.D., former editor of *The Journal of the American Medical Association,* and former president of the Pharmaceutical Manufacturer's Association, who has been a guest speaker at several KMA meetings, is now serving as vice-chairman of the Board of Directors of Parke, Davis and Company.

Ky. Diabetes Assn. to Meet

The Kentucky Diabetes Association will hold its annual interim meeting May 12 at the University of Kentucky Medical Center, according to John B. Selby, M.D., Lexington, secretary and program chairman.

A morning board meeting will be held prior to registration, which begins at noon. The general session will begin at 1:00 p.m. in room MN 442. Speakers will discuss problems in the production and action of insulin. All physicians and members of allied professions are invited to attend.

Appendectomies: Review

(Continued from Page 233)

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4. Thieme, E. T.: Appendicitis—A Fifteen Year Survey, *Arch. Surg. 70*:207-212 (Feb.) 1955.
5. Behrend, A.: Changing Patterns in Appendicitis. *J. A. Einstein Med Ctr., 9*:238-242 (Oct.), 1961.
6. Lee, J.A.H.: "Appendicitis" in Young Women. *Lancet, 2*:815-817 (Oct.) 1961.
7. Eisele, C. W., Slee, V. N. and Hoffman, R. G.: Can The Practice of Internal Medicine be Evaluated? *Ann Int. Med., 44*:144-161, (Jan.), 1956.

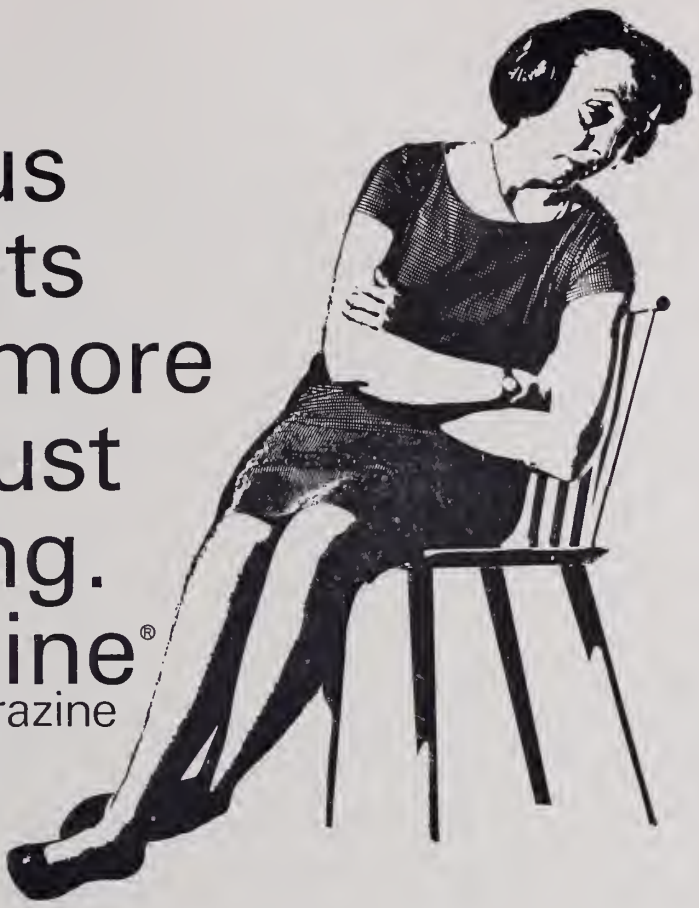
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Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.

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Physicians in Current Draft Call Listed by Selective Service

Kentucky physicians recently inducted into the Armed Forces were listed just prior to press time by Colonel Everette S. Stephenson, director of Selective Service for Kentucky.

Named were James R. Baker, M.D., Whitesburg, a resident at Vanderbilt Hospital; James Woodford Curry, Jr., M.D., Louisville, a resident at St. Joseph Infirmary in Louisville; Jerry Wayne Martin, M.D., in practice at Bowling Green; Sam H. Reid, M.D., in practice at Danville; Bernard F. Sams, M.D., practicing in Louisville; and Thomas R. Watson, M.D., Paducah, a resident at Louisville General Hospital.

Others in the current call of inductees are in various stages of processing, Colonel Stephenson said.

W. O. Johnson Lecture Scheduled

John L. McKelvey, M.D., chairman of the department of obstetrics and gynecology at the University of Minnesota, will deliver the annual W.O. Johnson Memorial Lecture at Louisville General Hospital, Rankin Amphitheater, April 4. The lecture, sponsored by the Louisville Obstetrical and Gynecological Society, will be titled "Problems of Diagnosis and Treatment of Choriocarcinoma".

'Excellent Attendance' Recorded At Utilization Review Meeting

"Excellent attendance" was reported by the presidents of the Kentucky Medical Association and the Kentucky Hospital Association at the Institute on Hospital Utilization Committees, sponsored jointly with Kentucky Blue Cross-Blue Shield February 17 at the Executive Inn in Louisville.

Approximately 375 persons attended the meeting, which examined Utilization Review from the standpoints of the three groups. Representating KMA on the program were Everett H. Baker, M.D., Louisville, Association president, and George W. Pedigo, Jr., M.D., KMA vice-president from Louisville, who gave a talk entitled "Utilization from the Physician's Viewpoint."

Other speakers during the day-long session included W. Leon Hisle, Berea, president of KHA, D. Lane Tynes, Louisville, president of Blue Cross Hospital Plan, Inc.; Richard F. Manegold, M.D., director of the Department of Hospitals and Medical Facilities for the AMA; Vergil N. Slee, M.D., Ann Arbor, Mich., director of the Commission on Professional and Hospital Activities; and Avil L. McKinney, Louisville, director of Professional-Public Relations for Blue Cross.

Symposium on Rheumatic Diseases Scheduled for April 28 at LGH

The University of Louisville School of Medicine and the Kentucky Chapter of the Arthritis Foundation are sponsoring the Second Postgraduate Symposium on Rheumatic Diseases on Thursday, April 28, in the Rankin Amphitheater, Louisville General Hospital.

"Acute Inflammatory Arthritides" will be the theme of the conference. Topics to be considered will be: "Gout"; "Pseudogout"; "Reiter's Syndrome and Gonococcal Arthritis"; "Palindromic Rheumatism and other Rare Forms of Articular Inflammation"; and "Synovial Fluid Analysis". David H. Neustadt, M.D., chief of the section of rheumatic diseases at the University of Louisville, is program chairman.

The guest faculty will include Alexander Gutman, M.D., New York City; John Talbott, M.D., Buffalo; Daniel J. McCarty, Jr., M.D., and Ralph A. Jessar, M.D., Philadelphia; Max Montgomery, M.D, Chicago; L. Emerson Ward, M.D., Rochester, Minn.; and Ann Gettes, M.D., Lexington, Ky.

The program is acceptable for continuation study credit by the American Academy of General Practice. See advertisement, page 000, for further information.

L. E. Smith Lecture Set March 25

"New Developments in the Diagnosis and Treatment of Emphysema" will be the topic of the first annual L.E. Smith Memorial Lecture to be delivered by Ben V. Branscomb, M.D., Birmingham, Ala., at Rankin Amphitheater, Louisville General Hospital, March 25. The lectureship, sponsored by the Kentucky TB and RD Association, is named in honor of the late Lucius E. Smith, M.D., a pioneer in tuberculosis control in Kentucky.

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QUINAMM Prescribing Information: Composition: quinine sulfate 250 mg. and aminophylline 200 mg. per tablet. **Precautions:** aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue if ringing in the ears, deafness, skin rash or visual disturbances occur. Since Quinomm cantoins quinine sulfate, coutian shauld be observed regarding administratian during pregnancy. Dosage: 1 tablet three or four times daily. For nacturnal leg cramps, 1 tablet an retiring.

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KMA Council and Committee Reports

Joint Meeting

Advisory Committee to University of Louisville
George A. Sehlinger, M.D., Louisville, Chairman

Advisory Committee to University of Kentucky
Andrew Moore, M.D., Lexington, Chairman

KMA Headquarters Office **January 6, 1966**

The Advisory Committees to the University of Louisville School of Medicine and the University of Kentucky College of Medicine met jointly recently at KMA Headquarters Office.

Members of the committees discussed the Conference on Medical Education scheduled for January 21-23 at the Park Mammoth Resort. It was pointed out the purpose of the conference is to provide an opportunity for appropriate representatives of KMA and members of the faculty of the two medical schools to discuss matters of mutual interest that would lead toward better understanding and help facilitate programs of the two schools and KMA.

The committees accepted for informational purposes several items that were considered by the AMA House of Delegates at Philadelphia last November. Considerable discussion revolved around the Coggshell Report, "Planning for Medical Progress Through Education." The committee has scheduled another meeting for May 12.

Mental Health Committee

Logan Gragg, Jr., M.D., Lexington, Chairman

KMA Headquarters Office **January 13, 1966**

At the recent meeting of the KMA Committee on Mental Health, members heard a report from Dale H. Farabee, M.D., Commissioner of Mental Health in Kentucky. Members of the committee discussed with Doctor Farabee mental health activities and programs now underway in the state and planned future work of the KMA Mental Health Committee to coincide with some activities in Doctor Farabee's department.

Committee members agreed that better liaison should be maintained with county society mental health chairmen. It was felt that more non-psychiatric physicians should be encouraged to become interested in the field of mental health.

Members discussed the up-coming 12th Annual Conference of State Mental Health Representatives to be held in Chicago in March and noted that several of the committee members were planning to attend.

Industrial Medicine Committee

Walter L. O'Nan, M. D., Henderson, Chairman

KMA Headquarters Office **January 26, 1966**

The KMA Industrial Medicine Committee met at the Headquarters Office and members heard several reports regarding meetings pertaining to occupational health. Informational material on occupational health was distributed to members of the committee for review.

Committee members felt the duties and name of the committee should be more inclusive and more up-to-date and recommended that the name be changed from Industrial Medicine Committee to Committee on Occupational Health. Several other recommendations were also made to the House of Delegates. The committee plans to meet again on April 20 at which time it will prepare its final report to the House of Delegates.

Mouthguards for Athletes

(Continued from Page 230)

Conclusion

It's high time that some teeth are put into the rules requiring the wearing of adequate mouthguards thereby aiding in keeping some teeth in the mouths of the participants.

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2. Connelly, C. C., Jr., Football Coaches on Mouth Protectors. *Journal of Missouri State Dental Association, Vol. 43,* April 1963.
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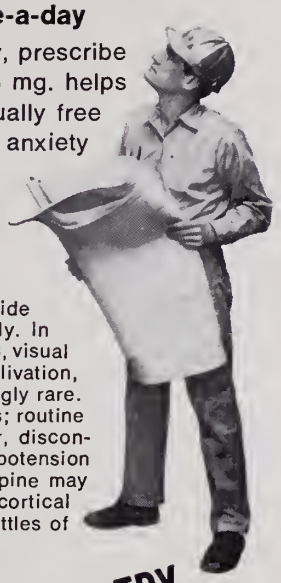
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Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

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COUNTY SOCIETY REPORTS

McCracken

The regular meeting of the McCracken County Medical Society was held at the Paducah Country Club on January 27. The Society acted as host to the members of the First KMA Trustee District.

Following a dinner and the meeting of the First District, the Society held a short business meeting presided over by Walter R. Johnson, M.D., Paducah, president. After dispensing with the reading of the minutes of the last meeting, the Censorship Committee presented their approval of the application for membership of Carl Henry, M.D.

A motion was made, seconded, and passed unanimously that Doctor Henry be accepted for membership. The meeting adjourned at 9:10 p.m.

Following is a list of county medical society officers recently reported to the KMA Headquarters office. Lists of all officers reported will be published in subsequent issues of The Journal.

Adair

President, George O. Nell, M.D., Columbia; secretary, W. Todd Jeffries, M.D., Columbia; delegate to KMA, J. C. Salato, M.D., Columbia; alternate delegate, Doctor Nell.

Christian

President, Fred T. Harned, M.D.; vice-president, Raymond C. Snowden, M.D.; secretary-treasurer, Edwin R. Davis, M.D.; delegates, W. Faxon Payne, M.D. and Norma T. Shepherd, M.D.; alternate delegates, Preston T. Higgins, M.D., and Robert M. Coleman, M.D. All are from Hopkinsville.

Cumberland

President, W.F. Owsley, M.D.; vice-president, Robert B. Chambliss, M.D.; secretary, Joseph Schickel, M.D.; delegate to KMA, Doctor Chambliss; alternate delegate, Doctor Schickel. All are from Burkesville.

Estill

President, R.R. Snowden, M.D., Ravenna; vice-president, O.C. Amstutz, M.D., Irvine; president-elect, S.G. Marcum, Irvine; secretary, Virginia Wallace, M.D., Irvine; delegate, Doctor Wallace; alternate, Doctor Marcum.

Fayette

President, Irving F. Kanner, M.D.; vice-president, David B. Stevens, M.D.; president-elect, John F. Berry, Jr., M.D.; secretary-treasurer, Gordon L. Hyde, M.D. Delegates are: John F. Berry, Jr., M.D., W.L. Blakey, M.D., N.L. Bosworth, M.D., T.R. Bryant, M.D., Richard D. Floyd, M.D., Carl H. Fortune, M.D., David A. Hull, M.D., Irving F. Kanner, M.D., Graydon A. Long, M.D., Andrew M. Moore, M.D., John E. Myers, M.D., Joseph H. Saunders, M.D., and R.D. Shepard, M.D. Alternates are: D.E. Edger, M.D., and R.B. McElvein, M.D. All are from Lexington.

Fleming

President, W.A. Graham, M.D.; vice-president, Samuel W. Gehring, M.D.; secretary-treasurer, Ben F. Allen, M.D.; delegate, Doctor Gehring; alternate delegate, Robert W. Fidler, M.D. All are from Flemingsburg.

Grant

President, Claude C. Waldrop, M.D.; vice-president, Darl B. Shipp, M.D., Dry Ridge; secretray-treasurer, Lenore P. Chipman, M.D., Williamstown; delegate, Doctor Chipman; alternate delegate, Doctor Shipp.

Graves

President, Francis J. Dillard, M.D.; vice-president, James E. Albritton, M.D.; secretary-treasurer, Larry L. Hall, M.D.; delegate, A. Reeves Morgan, M.D.; alternate, Doctor Hall. All are from Mayfield.

Hardin-Larue

President, C. E. Hernandez, M.D.; vice-president, Thomas J. Ferriell, M.D.; secretary-treasurer, Ollie B. Emerine, M.D.; delegate, Fred C. Rainey, M.D.; alternate delegate, W. A. Litzenberger, M.D. All are from Elizabethtown.

Jefferson

President, Hoyt D. Gardner, M.D.; president-elect, Edwin P. Solomon, M.D.; secretary, William Sandman, M.D.; treasurer, James Linville, M.D.

Following are the delegates: Harold W. Baker, M.D., Melvin Bernhard, M.D., Sam Black, M.D., Eugene H. Conner, M.D., K. P. Crawford, M.D., John Doyle, M.D., William Durham, M.D., Louis Foltz, M.D., Wilfred Gettelfinger, M.D., John Goldsborough, M.D., Richard F. Greathouse, M.D., John Harter, M.D., John Hemmer, M.D., Walter I. Hume, Jr., M.D., David Kinnaird, M.D., Herman Mahaffey, M.D., Robert McClendon, M.D., William Mitchell, M.D., Herman Moore, M.D., Gerald Peterson, M.D., Henry Post, M.D., John Robbins, M.D., W. Fielding Rubel, M.D., William T. Rumage, Jr., M.D., George Sehlinger, M.D., Donn L. Smith, M.D., William Stodghill, M.D., Donald Varga, M.D., William Vonderhaar, M.D., John Woolford, M.D., and Lloyd Yopp, M.D.

(Continued on Page 266)

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

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Alternate delegates are: Harold Eskind, M.D., James Marshall, M.D., James Parker, M.D., Charles Sergeant, M.D., Charles B. Severs, M.D., Harry Stambaugh, M.D., Robert Stansbury, M.D., Stuart Urbach, M.D., and Robert Woodard, M.D.

Johnson

President, Jerry D. Fraim, M.D.; vice-president, Robert A. Hall, M.D.; secretary-treasurer, Paul B. Hall, M.D.; delegate to KMA, A.B. Carter, M.D.; and alternate delegate, Doctor Robert Hall. All are from Paintsville.

Letcher

President, J.B. Tolliver, M.D., Whitesburg; vice-president, John E. Engle, M.D., Whitesburg; secretary-treasurer, Carl Pigman, M.D.; delegate, Doctor Tolliver; alternate, T.M. Perry, M.D., Jenkins.

Madison

President, Clifford F. Kerby, M.D., Berea; vice-president, A.B. Clark, M.D., Richmond; secretary-treasurer, Robert Long, M.D., Berea; delegates, William D. Epling, M.D., Berea, and Douglas H. Jenkins, M.D., Berea.

McCreary

Secretary, M.A. Winchester, M.D., Whitley City; delegate, H.A. Perry, M.D., Stearns.

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In Memoriam

CLARENCE H. LIKINS, M.D.
Louisville, Ky.
1897 - 1966

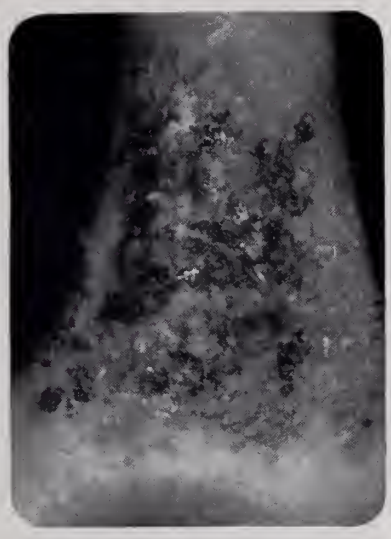
C. H. Likins, Sr., M.D., Louisville anesthesiologist, died suddenly February 15 during a meeting at the Bank of Caneyville, Caneyville, Ky., of which he was a member of the Board of Directors. Doctor Likins, a 1921 graduate of the Medical Department of the University of Louisville, was an emeritus member of KMA and belonged to a number of other medical societies, both state and national.

THOMAS J. SNIDER, M.D.
Taylorsville, Ky.
1881 - 1966

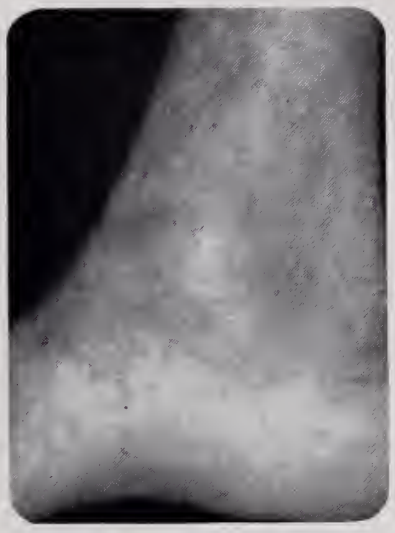
T. J. Snider, M.D., 84, a general practitioner in Spencer County since his graduation from the old Louisville and Hospital College of Medicine in 1908, died February at a Louisville hospital. He would have been 85 on March 4. Doctor Snider was a member of KMA and a Scottish Rite Mason.



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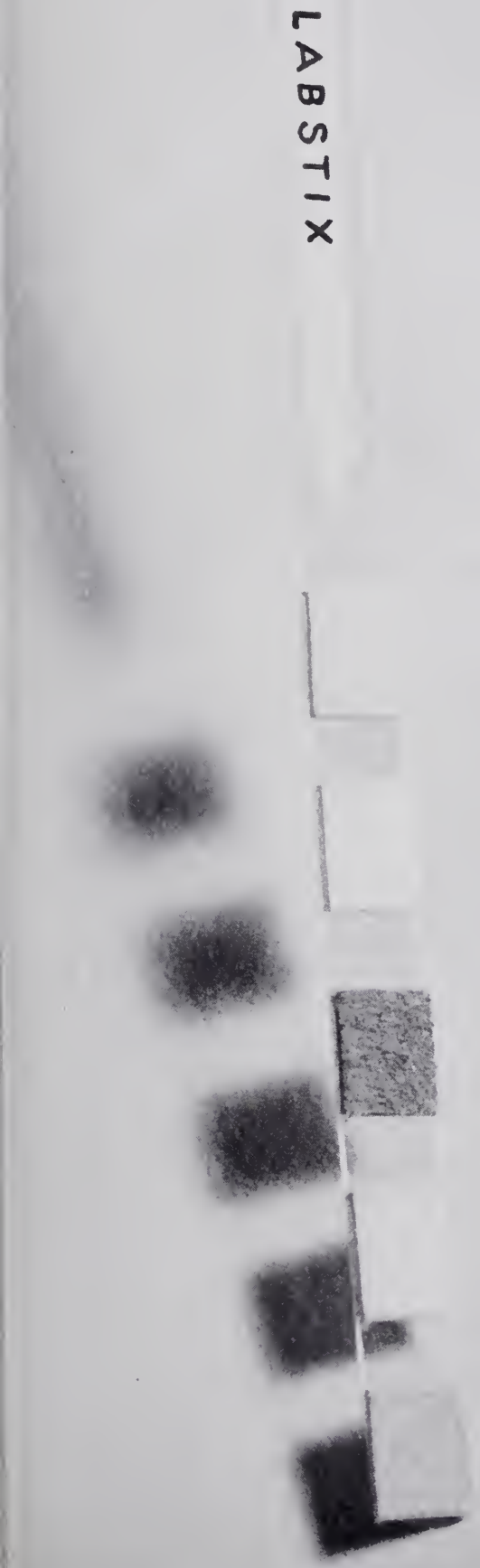
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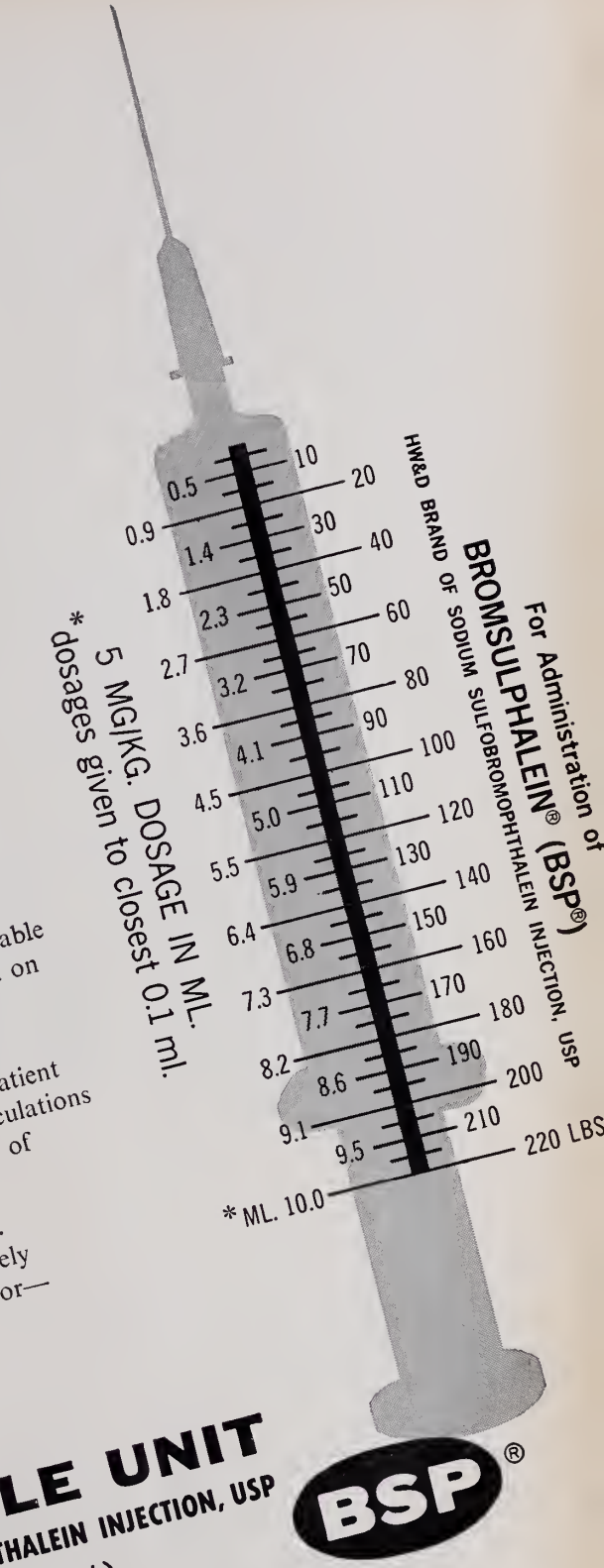
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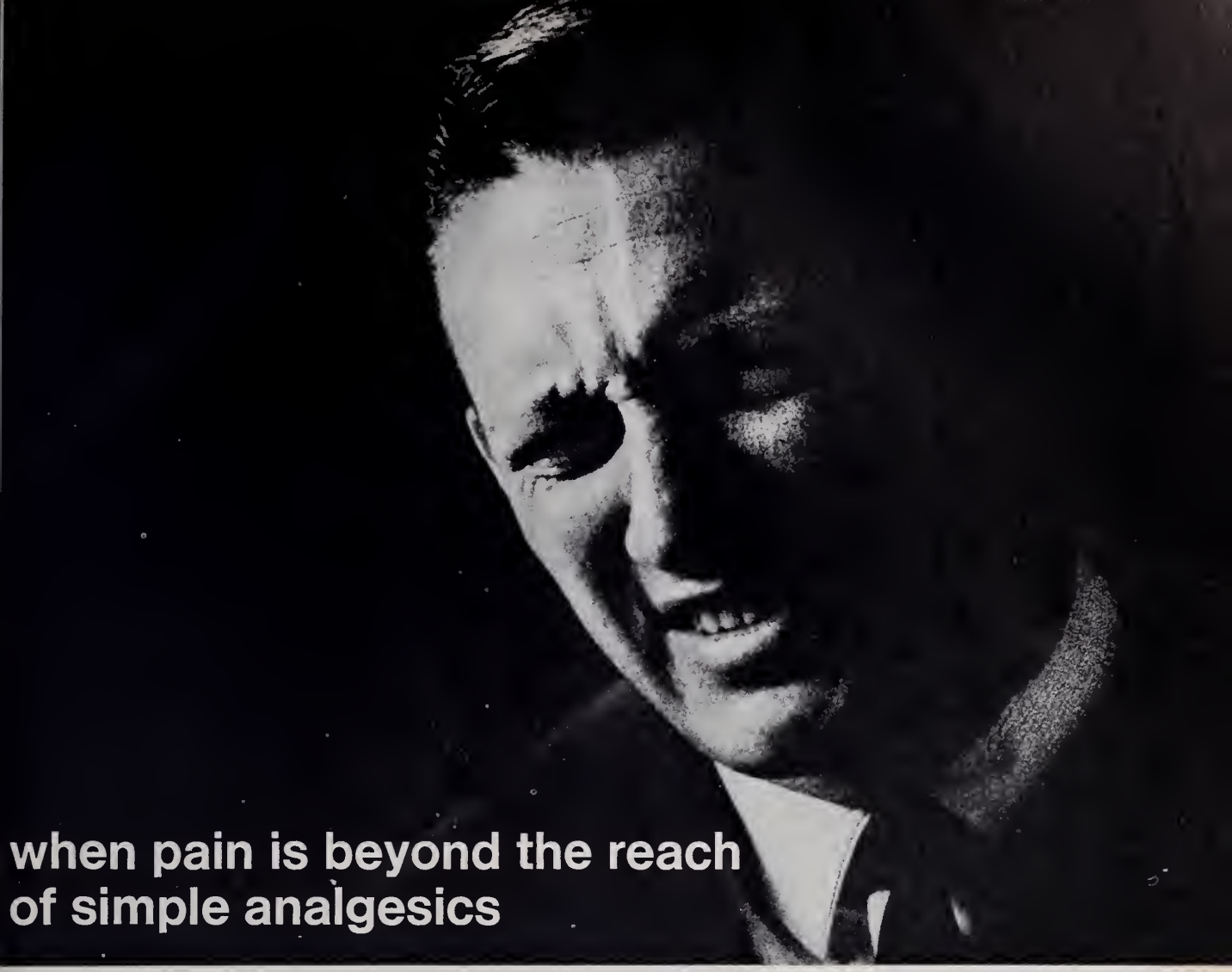
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1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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MESSAGE FROM THE PRESIDENT



To This Point

WE HAVE NOW passed the halfway point of this year: 1965-66. What has been accomplished and what is planned for the second half of the year?

We have seen the McDowell house receive National recognition.

Two conferences have been held with our governor regarding health facilities in our state and he promised to consult with us and to seek our advice on all such matters.

The Allied Medical Council met twice to study problems of interest with an exchange of ideas that were fruitful.

Park Mammoth was the site of a three-day meeting of Town and Gown. Deans of U. of L. and U. of K. schools of medicine with 15 of each faculty met with 30 practicing physicians. The theme was medical education and the responsibility of the physician to the university and the university to the physician and his community. A great meeting, it was.

Much activity centered about Frankfort with Legislative key men working at all times to have enacted those things that would best serve our people and our Commonwealth.

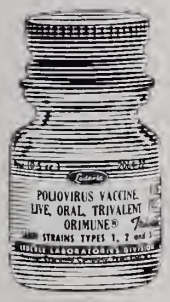
There is much work just beginning on the study of KMA structure with plans for reorganization. We ask ourselves at all times—are we working as hard as we should in certain areas, and are we spending too much time and effort in other areas? A careful appraisement of all activities and expenditures by an erudite group of our colleagues will be given to us in a report for our study.

Utilization Review and other matters relating to the implementation of PL 89-97 and July 1, 1966 appear in the second half of our year. The impact will be great to the physician and to the hospital. We have shared and we have planned.

May we face this new challenge with equanimity and high purpose. In secular literature Polonius pointed the way in his advice to Laertes and in Holy Writ we find our greatest guideline in the Sermon on the Mount.

Everett H. Baker

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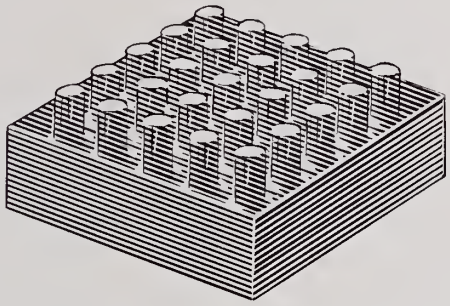


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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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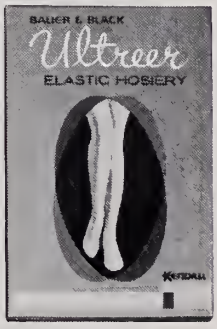


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1. Population Expansion, 2. Emphysema, 3. Burns, 4. Mysterious Fevers, 5. Community Hospital and Coronary Care Units, 6. Headache

In addition, 23 Sections will present scientific programs and many of these will be Joint Meetings of one or more Sections, and in some instances, a Specialty Society.

- The American College of Chest Physicians will again join the AMA Section on Diseases of the Chest in an all day program.
- The American College of Cardiology and the American Heart Association will join the AMA Section on Internal Medicine in a half-day session.
- The American Congress of Physical Medicine and Rehabilitation and the Mid-America Society of Physical Medicine and Rehabilitation will meet jointly with the Section on Physical Medicine.
- The American Society of Clinical Pathologists will join the AMA Section on Pathology and Physiology in a half-day session on Computers in Medicine.
- The International Academy of Pathology will join the Section on Pathology and Physiology in a full day's program on Tropical Medicine.
- The AMA Committee on Blood and the Section on General Practice will present a half-day session.
- The Society for Investigative Dermatology, Inc. will hold its meetings in conjunction with the Section on Dermatology, and the Association for Research in Ophthalmology, Inc. in conjunction with the Section on Ophthalmology.
- The Sixth Multidiscipline Research Forum will be held under the auspices of the Section on Experimental Medicine and Therapeutics.
- Three Special Sessions—on Nursing, Maxillofacial Surgery and Nuclear Medicine—under the Section on Miscellaneous Topics.
- Medical Motion Pictures and Color Television will be presented daily. Some of the Sections will participate in the Television program.
- Approximately 350 scientific exhibits will be presented.

FOR ROOM RESERVATIONS PLEASE PRINT OR TYPE SIX CHOICES

1st_____
2nd_____
3rd_____
4th_____
5th_____
6th_____

Please enter my reservation at the above hotel/motel for

Single(s) ☐ @ $____ Double(s) ☐ @ $____ Twin(s) ☐ @ $____ Suite(s) ☐ @ $____

Room will be occupied by:

Name_____ (Please print or type)

Street_____

City State Zip Code

Additional Occupants_____

Date Arriving_____ Hour AM PM _____ Departing

Confirmations will be mailed up to June 22.

AMA | 1966 | CHICAGO

This form may also be used for meetings (June 23-26), prior to AMA Convention, but rooms must be released on date indicated.

If you are an industrial exhibitor, be sure to give name of firm and individuals to occupy room or rooms reserved. Please make all changes and cancellations through the Housing Bureau. Hotel reservations will be held only until 6 p.m. unless otherwise specified.

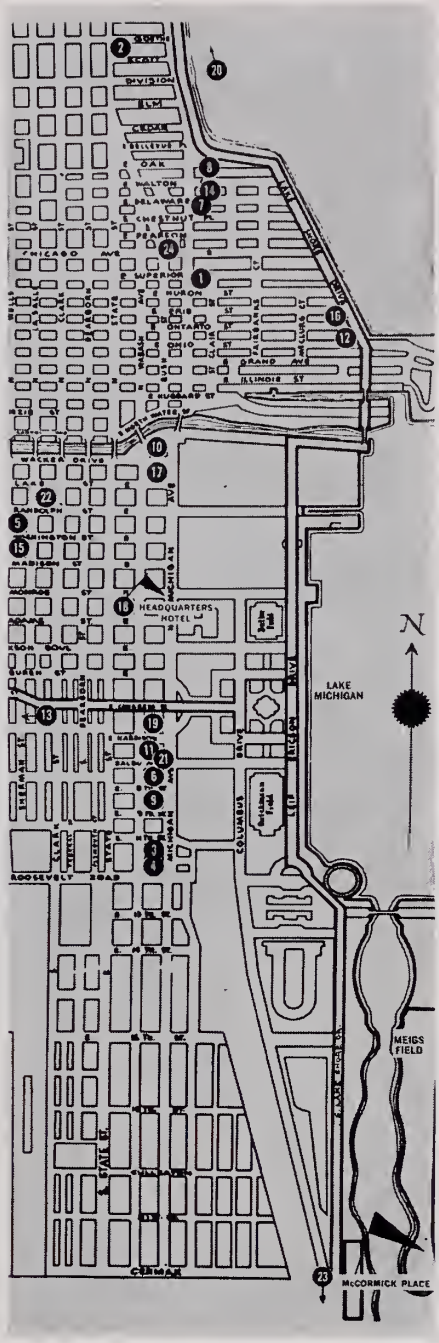
TO ASSURE YOUR ACCOMMODATIONS AT THE 115th ANNUAL CONVENTION

Fill In The Coupon Below and Mail Directly To:

AMA HOUSING BUREAU
THE CHICAGO CONVENTION BUREAU
332 South Michigan Ave.
Chicago, Illinois 60604

Blocks of rooms are held in the hotels and motels listed below for the American Medical Association.
These rooms are available only through the AMA Housing Bureau.

	NAME	SINGLES	DOUBLES	TWINS	SUITES
1.	Allerton Hotel	10.00		14.00-15.00	
2.	Ambassador Hotels	14.00-18.00	15.00-32.00	18.00-32.50	30.00-47.00
3.	Ascot House	13.50-17.00		18.00-24.00	45.00-55.00
4.	Avenue Motel	13.50-15.00		18.00-22.00	45.00
5.	Bismarck Hotel	12.00-19.00	14.00-20.00	16.50-24.00	35.00-55.00
6.	Conrad Hilton Hotel	10.00-15.50	18.50-25.00	19.00-31.00	35.00-125.00
7.	Continental Plaza	22.00-25.00	30.00	27.00-29.00	
8.	Drake Hotel (Woman's Auxiliary Headquarters)				
9.	Essex Inn	14.00-18.00		18.00-24.00	50.00-75.00
10.	Executive House	16.00-21.00	20.00-25.00	20.00-25.00	37.50-47.50
11.	Harrison Hotel	9.00-12.00	12.50-17.00	14.00-17.00	
12.	Holiday Inn	12.50-15.50	15.00	18.50	
13.	Imperial Inn		26.00	24.00-26.00	35.00
14.	Knickerbocker Hotel	12.00-16.00		16.00-20.00	
15.	LaSalle Hotel	10.00-16.00	14.00-18.00	16.00-23.00	
16.	Lake Tower Inn	12.00-15.00	17.00-19.00	18.00-22.00	42.00
17.	Oxford House	18.00	22.00	22.00	35.00-65.00
18.	Palmer House (HEADQUARTERS HOTEL; LIMITED NUMBERS OF ROOMS AVAILABLE)	12.00-24.50	19.50-25.50	21.50-30.50	
19.	Pick-Congress Hotel	10.00-18.00	12.00-21.00	16.00-23.00	30.00-110.00
20.	Sands Motel	12.00	16.50		
21.	Sheraton-Blackstone Hotel	9.00-11.50	16.50-19.50	21.50	38.50-88.50
22.	Sherman House	8.00-15.00	14.00-20.00	15.00-22.00	30.00-70.00
23.	Shore Drive Motel	12.00-15.00	16.00-22.00	16.00-22.00	30.00-50.00
24.	Water Tower Inn	20.00-22.00	24.00-26.00	26.00-28.00	30.00-34.00



- If rate requested is not available, next highest will be assigned.
- Be sure and specify time of arrival as well as date.
- If you are an Industrial Exhibitor, please specify firm name and list of all occupants for all rooms reserved.
- Please make all changes and cancellations with the Housing Bureau.
- A three per cent (3%), Illinois Hotel Operators' Occupational Tax is applicable to all hotel rates.
- Reserve rooms as soon as possible. Assignments will be made in the order requests are received.
- Please DO NOT send your request directly to the hotel; it will only delay your confirmation.

Make your reservation now for Chicago—avoid the rush—avoid the lines

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials—usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

Indications: Diarrhea. *Contraindications:* Kaolin: Withhold if diverticulosis is present or suspected. *Precautions:* Sulfonamide: Continued use requires supplementary administration of thiamine and vita-

your ℞ for Cremomycin can provide relief



min K. Neomycin: Patient should be observed for new infections due to bacteria or fungi. *Side Effects:* Sulfonamide: Sensitivity reactions may occur (e.g., skin rashes, anemia, polyneuritis, fever; agranulocytosis with a fatal outcome has been reported). Reduction of thiamine output in the feces and of vitamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.

Before prescribing or administering, read product circular with package or available on request.

promptly relieves diarrheal distress

Cremomycin®

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy



THE INSURANCE PAGE



KENTUCKY Blue Cross-Blue Shield members 65 years of age or over are being offered a new, specially designed, low-cost supplementary hospital-surgical plan, called "Blue Cross-Blue Shield 65." The new plan extends, but does not duplicate, Medicare benefits.

Letters regarding the new program, along with descriptive literature and transfer applications will be mailed before April 1 to all non-group members 65 years of age or over. All companies enrolled in Blue Cross-Blue Shield are being contacted by staff members regarding the supplementary protection for their employees or spouses who are eligible for Medicare.

Also, as a public service, any Kentuckian 65 years of age or over enrolled in Part A and Part B of Medicare, who can meet underwriting health requirements and who is not a member of Blue Cross-Blue Shield, will be given an opportunity to apply for the supplementary protection between April 15 and June 1.

Persons who become 65 years of age after July 1 may apply for this new program 60 days before to 30 days after their 65th birthday.

Blue Cross-Blue Shield 65 will provide benefits that are not included in Medicare, such as the first $40.00 of the hospital bill and $10 per day for the 61st through the 90th day, and hospital services for emergency treatment of accidental injuries or a sudden and serious medical condition.

Special attention is called to the "Extended Benefits" portion of the "Blue Cross-Blue Shield 65" program.

"Blue Cross-Blue Shield 65" EXTENDED BENEFITS begin where the other services leave off, providing the following benefits in addition to those provided by Medicare Parts A and B, and those provided by "Blue Cross-Blue Shield 65."

After a $100 deductible (paid by the member) per calendar year, (the $50 Medicare deductible is credited toward this):

EXTENDED BENEFITS will pay the following covered hospital-medical charges:

* 20% of doctors' reasonable charges (not paid by Medicare). 80% of the following charges:

* Semi-private room and hospital care,

* All ancillary services in the hospital such as operating room, laboratory exams, medicines, etc.

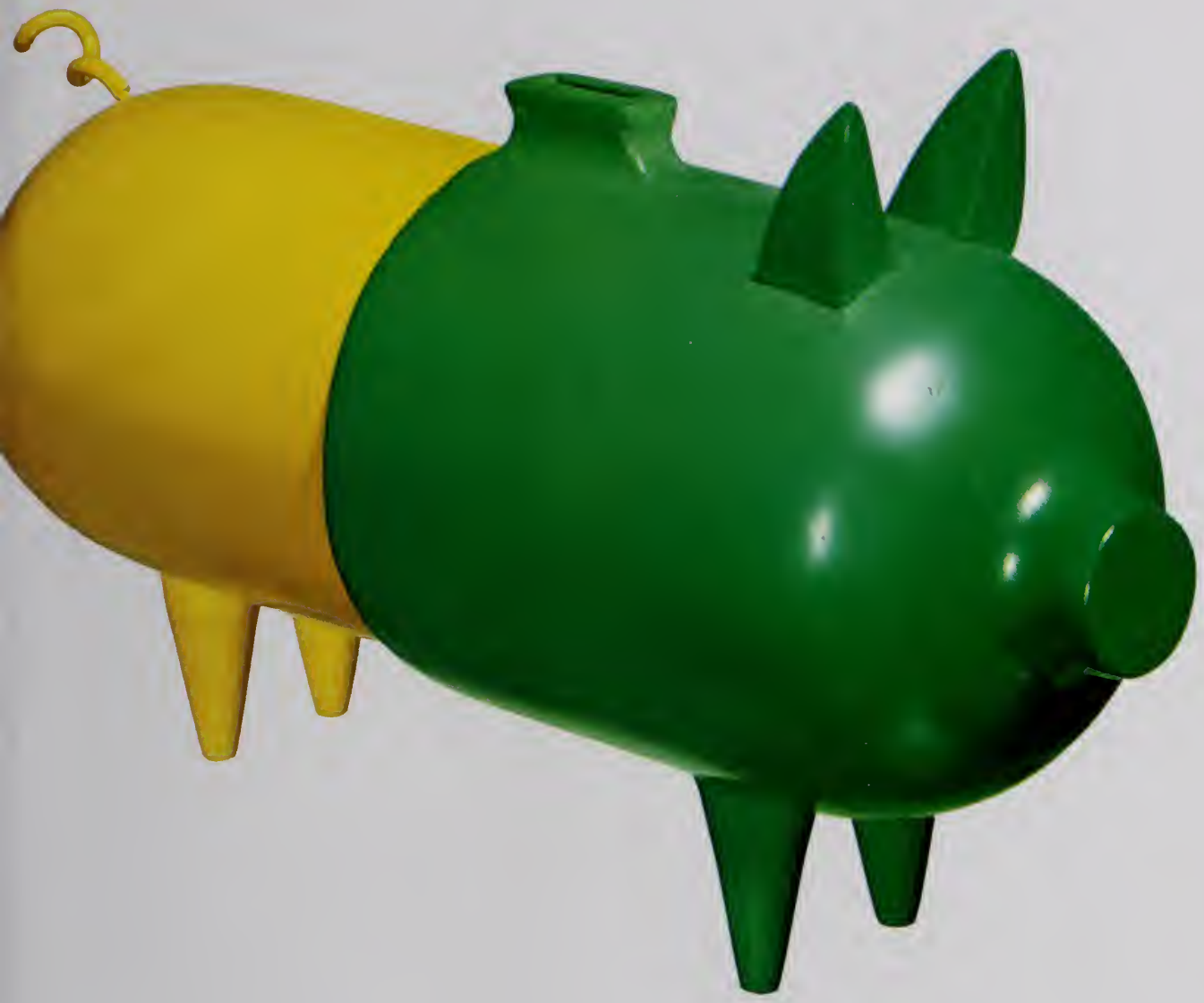
* Rental of equipment and orthopedic and prosthetic appliances,

* Services of a qualified professional physical therapist,

* Outpatient mental (psychiatric) treatment will be reimbursed at 50% of the amount in excess of the deductible,

* Lifetime Maximum — $5,000.

WILLIAM W. HALL, M.D.



ECONOMY

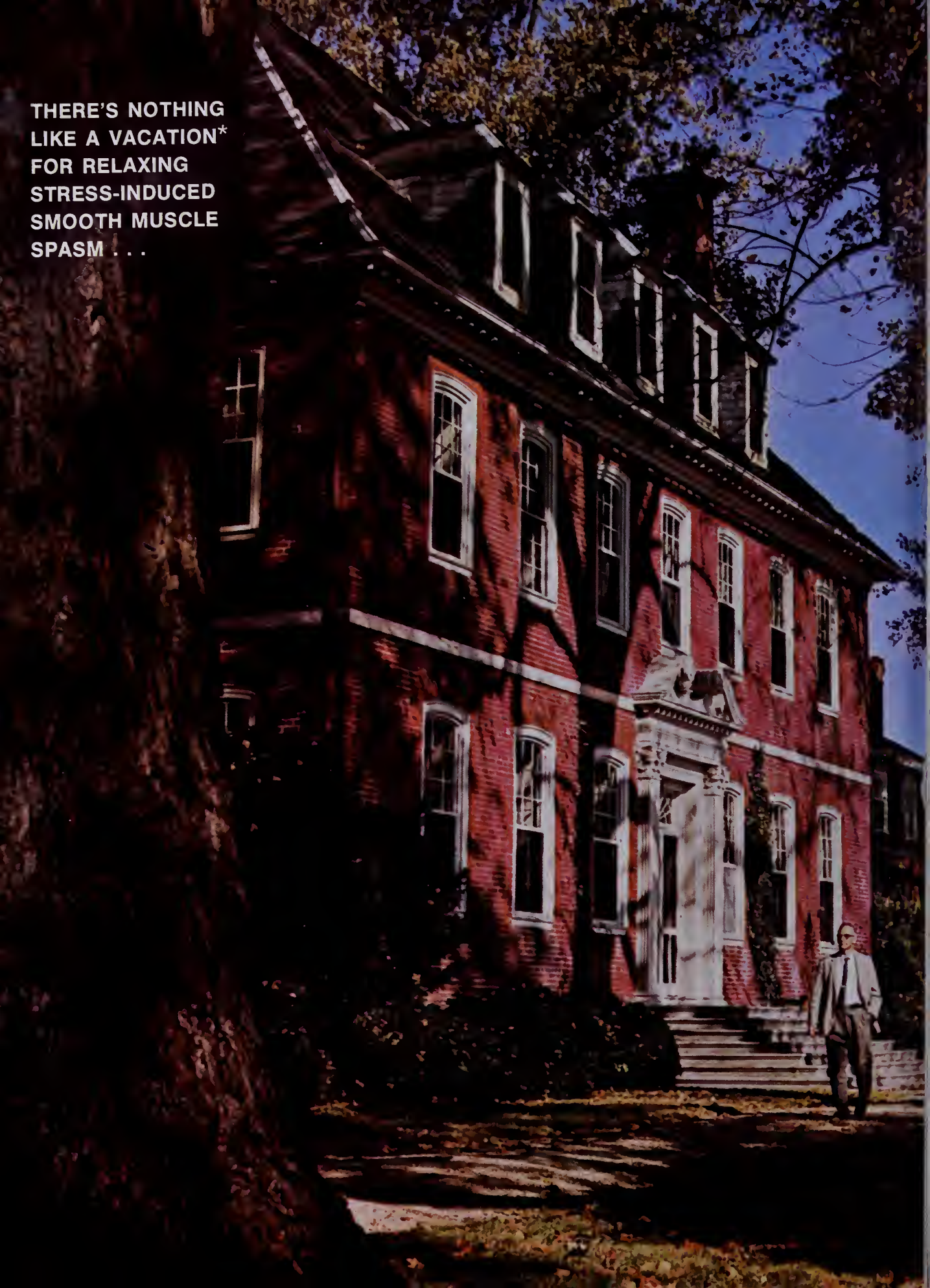
When you prescribe or recommend Allbee with C, you can be sure your patient is getting a rational, specific multivitamin formulation at an economical price. The potent formula is sensible and simple. It contains therapeutic amounts of the water-soluble B and C vitamins. These vitamins are expended rapidly in the body and need to be replenished frequently. There are no extraneous factors, no frills in Allbee with C. It's the no-nonsense vitamin in the yellow and green capsule that always gives your patient his money's worth.

Each capsule contains: Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine hydrochloride (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

A. H. ROBINS COMPANY, INC.,
RICHMOND, VIRGINIA 23220 A·H·ROBINS

—a good reason for 

ALLBEE® WITH C


THERE'S NOTHING
LIKE A VACATION*
FOR RELAXING
STRESS-INDUCED
SMOOTH MUSCLE
SPASM . . .

. . NOTHING, THAT IS,
EXCEPT THE SEDATIVE-ANTISPASMODIC
BENEFITS OF

DONNATAL®

IN EACH TABLET, CAPSULE, OR (5 cc.) OF ELIXIR

hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
phenobarbital	(1/4 gr.) 16.2 mg.

(warning: may be habit forming)

IN EACH EXTENTAB

hyoscyamine sulfate	0.3111 mg.
atropine sulfate	0.0582 mg.
hyoscine hydrobromide	0.0195 mg.
phenobarbital	(3/4 gr.) 48.6 mg.

(warning: may be habit forming)

There's nothing quite like a vacation to ease the pressures of the modern, "workingday" world. And for the patient who can't get away from it all, there's nothing quite like Donnatal to relax stress-induced smooth muscle spasm. For 31 years it has been the antispasmodic-sedative most often prescribed for relieving functional disturbances of tone and motility of the gastrointestinal tract.

belladonna alkaloids in optimally balanced ratio

In Donnatal, natural belladonna alkaloids are rationally balanced in a specific, fixed ratio that provides "the greatest efficacy with the smallest possible dose."[1] They avoid the clinical uncertainties of the variable tincture and extract of belladonna, and are considered superior in range of action to atropine alone.[2] Furthermore, they are generally recognized as being more effective than the synthetics for relieving visceral spasm.

phenobarbital for sedation

Years of clinical use have established phenobarbital as one of the most efficient and highly regarded sedatives. In fact, for general sedation it is the drug of choice.[3] In Donnatal, phenobarbital potentiates the spasmolytic effects of the belladonna alkaloids, lessening emotional tensions and checking the neurogenic impulses that trigger GI disorders.

more than 24 indications in PDR

Donnatal has withstood the test of time to become the classic sedative-antispasmodic because of its unsurpassed effectiveness, safety, economy, uniformity of composition, and dosage convenience. Its widespread acceptance and usage by the profession can also be attributed to its versatility in treating disorders characterized by smooth muscle spasm. There are more than two dozen distinct and separate indications for Donnatal listed in the current PDR.

BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

A. H. ROBINS COMPANY, INC., RICHMOND, VA.

A·H·ROBINS

Thanks to Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

she can say "No thank you" to the crêpe suzette.

'Dexamyl' does more than most anorectics. Because it curbs appetite *and* lifts mood, 'Dexamyl' can encourage the discouraged dieter to stay on her diet.

The mood lift with 'Dexamyl' can make the difference between the success or failure of her diet plan.

Formulas: Each 'Dexamyl' Spansule® Capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

Smith Kline & French Laboratories SK&F



The discomforts of

DIARRHEA
MUCOUS COLITIS
DIVERTICULITIS
SPASTIC URETERITIS
BLADDER SPASM

. . . are relieved by direct musculotropic action with



Trocinate®

BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

Trocinate *BRAND* THIPHENAMIL HCl

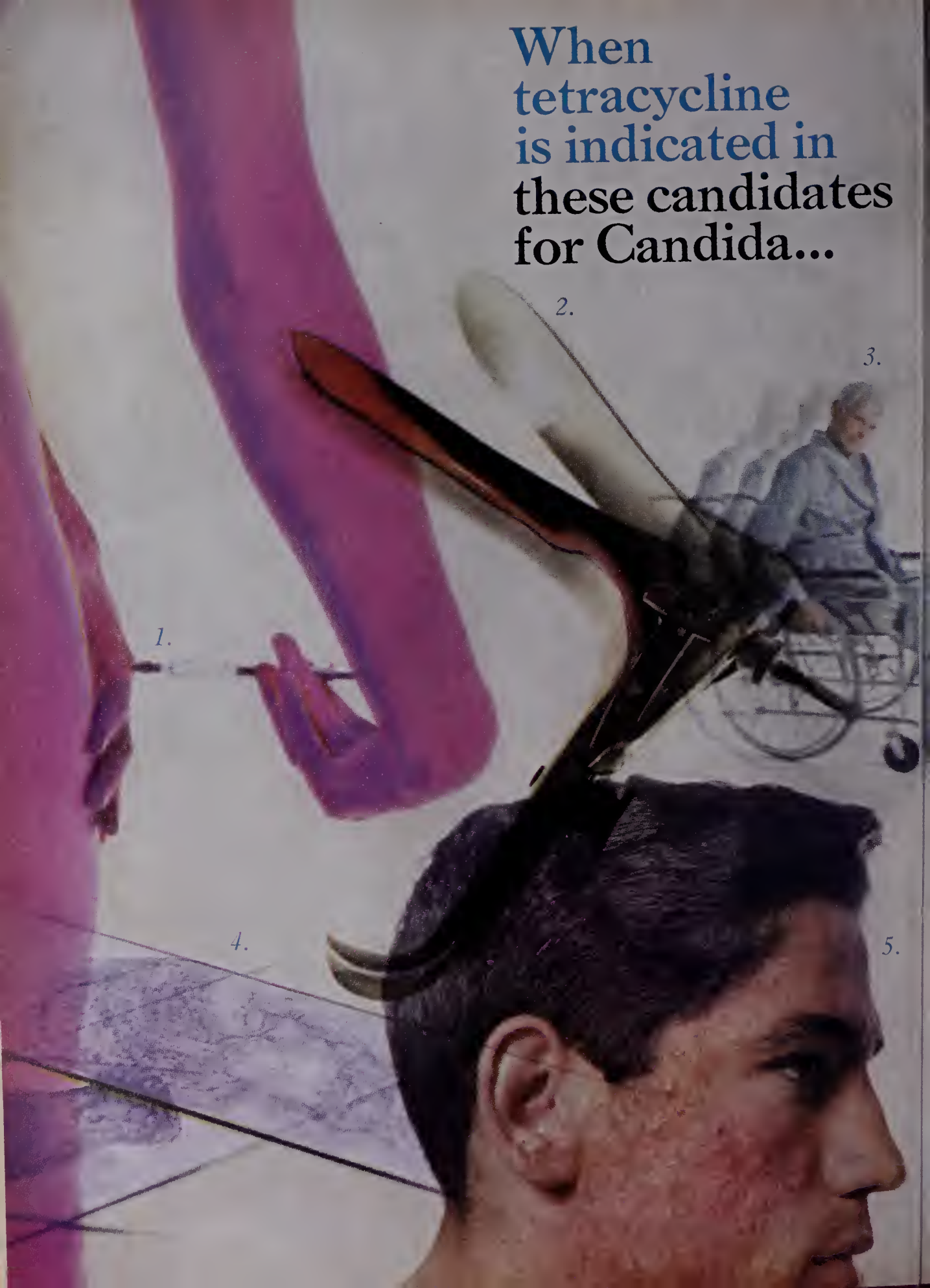
BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

. . . directly relaxes smooth muscle spasm
. . . combats hypermotility
. . . non-mydriatic – may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856


When
tetracycline
is indicated in
these candidates
for Candida...
1.
2.
3.
4.
5.

New low-cost tetracycline/ antifungal therapy

Tetrex®-F

tetracycline phosphate complex –nystatin

Because new Tetrex-F (tetracycline phosphate complex-nystatin) is the most economical therapy of its kind that you can prescribe, it is a sound choice whenever tetracycline therapy is indicated in patients predisposed to monilial infections.

Who are these "candidates for Candida"?

1. diabetic patients
2. nonpregnant women with a history of recent or recurrent monilial vaginitis
3. elderly or debilitated patients
4. patients with a past history of moniliasis
5. patients on long-term tetracycline or corticosteroid therapy.

For these patients, Tetrex-F (tetracycline phosphate complex-nystatin) provides efficient tetracycline therapy against a broad range of infections *plus* protection against superinfection associated with the overgrowth of *C. albicans* in the G.I. tract.

Priced for savings

Tetrex-F (tetracycline phosphate complex-nystatin) is lowest in cost—priced 20% lower than most tetracycline/antifungal products.

BRISTOL THERAPEUTIC SUMMARY

For complete information consult Official Package Circular.

Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.

Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dosage: 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.

Supply: Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. Oral Suspension, 60-ml. bottle. Each 5 ml. contains tetracycline equivalent to 125 mg. tetracycline hydrochloride and nystatin, 125,000 units.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York



BRING THE TREATMENT TOGETHER IN A SINGLE PRESCRIPTION

ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Contraindication: History of hypersensitivity to tetracycline. Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

6075-2912



The Pain Is Gone

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief

BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE 4-64. A 34 year old, married, white, gravida 8 para 4 who had experienced an uncomplicated pregnancy was admitted at term 7:45 A.M., on May 14, 1964 for an elective induction of labor. On examination, the temperature was 99° F, pulse 80, respiration 20, and blood pressure 140/80. The fetal heart beat was heard in the right upper quadrant, and was counted at 120 beats per minute. At 9:30 the patient was examined vaginally by her physician. The condition of the cervix was not recorded. At 9:40 A.M., an intravenous infusion containing 0.5 cc of Pitocin was started. She was checked vaginally at 10:45 by her physician and the membranes were ruptured artificially. The cervix was described as barely two fingers dilated with the presenting part at +1 station.

The patient was given 25 mg of Phenergan, 50 mg of Demerol and 1/150 gr of Hyoscine intramuscularly at 12:25 P.M.; 50 mg Demerol and 1/300 gr of Hyoscine were given intravenously at 2:00 P.M. She was checked at 2:30 P.M., and moved to the delivery room, where a Nupercaine and Neosynephrine block was performed at 3½ fingers of cervical dilation. Approximately ten minutes later she complained of feeling "funny" and had a convulsion-like seizure. The blood pressure was 70/0, oxygen was administered by the physician anesthetist and 22 cc of Levophed was added to the intravenous infusion. Blood was sent for immediate cross-matching for two pints of blood.

The patient was delivered at 2:58 P.M. of a living 7 lb., 9½ oz. male infant by a midforceps Scanzoni rotation from LOP-LOA over right mesolateral episiotomy. Following the delivery of the placenta at 3:02 P.M., the patient had a postpartum hemorrhage. The uterus, cervix, and vagina were explored and found intact. It was noted that the blood was not clotting. Three uterine packs were inserted, but the patient bled through the packs. A blood transfusion was started and two units of fibrinogen were given. A cutdown was performed in the left leg. Aramine (10 cc) was added to the Pitocin infusion. Blood was noted in urine obtained through a Foley catheter. At 6:25 P.M. a second 500 cc infusion of 5% glucose in water was started intravenously with 10 cc of Aramine and 200 mg of Solucorted added. A blood volume determination showed a deviation of almost 600 cc from the expected normal. The patient never regained consciousness after the convulsion, nor did she have detectable blood pressure. Permission for an autopsy was requested, but refused. The presumptive diagnosis was amniotic fluid embolism.

Comments

The Committee considered this to be a direct obstetric maternal death with preventable factors. The patient's difficulty began with the administration of the anesthetic. The possibility of total or too high an anesthetic was raised. If this were the case, simply breathing for the patient together with the administration of blood pressure stimulants such as Levophed would have solved the problem. Without an autopsy the possibility of unexpected uterine rupture could not be ruled out. The postpartum hemorrhage with the associated afibrinogenemia was thought to have possibly resulted from the midforceps delivery after the Scanzoni rotation. The observation of gross hematuria also suggested trauma, even though no laceration was found when the uterus and cervix was checked. Since two hours elapsed from delivery until death, there was time to ligate the hypogastric vessels; this procedure might have controlled the hemorrhage and afibrinogenemia.

WHY does a pickle processor make so many different varieties of pickles?



WHY does a hat maker fashion so many different kinds of hats?



WHY does a chair manufacturer create so many different styles of chairs?



WHY does a home builder build so many different types of homes?



. . . For the same reasons that

BLUE SHIELD® and BLUE CROSS®

Offer such a wide variety of Surgical-Medical and Hospital Protection Plans and Ranges of Benefits:

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MEN'S SHOP



. . . in the **SOUTHERN OPTICAL BUILDING,** 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

Southern Optical

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Contact Lens and Artificial Eye Service on Opthamologist's Prescription Only

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WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients . .

NEW CASTLE SANITARIUM

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NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

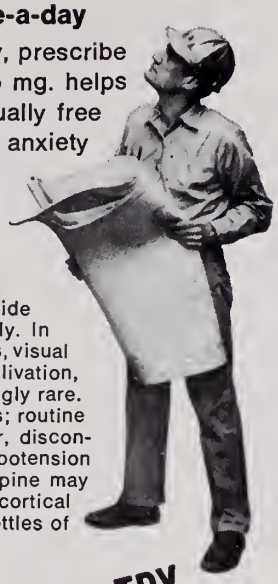
REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses

Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

THE SQUIBB TRANQUILIZER

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB Squibb Quality — the Priceless Ingredient

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

APRIL

12	KMA Senior Day, University of Kentucky Medical Center, Lexington
13-14	KENTUCKY MEDICAL ASSOCIATION Interim Meeting, Cumberland Falls
14-16	Kentucky OB-GYN Society Annual Meeting; Netherland Hilton Hotel, Cincinnati
18	KMA Fifth Trustee District Meeting, Medical Arts Building, Louisville
21	Kentucky Thoracic Society Annual Meeting, in conjunction with Kentucky TB & RD Association Meeting, Rankin Amphitheater, Louisville General Hospital
23	Kentucky Orthopedic Society, Springs Motel, Lexington
25-28	Kentucky Hospital Association Annual Meeting, Louisville
28	Ky. Chapter, Arthritis Foundation, Symposium on Rheumatic Disease, Co-sponsored by U. of L. School of Medicine. At Rankin Amphitheater, Louisville General Hospital

MAY

1-7	Immunization Week in Kentucky
2-6	Symposium on Cardiovascular Disease, University of Kentucky Medical Center
4	Professor's Day, University of Kentucky Medical Center, 8:30 a.m.-3:30 p.m.
11-13	Kentucky Academy of General Practice, Annual Scientific Assembly, Kentucky Hotel, Louisville
13-14	Kentucky Surgical Society Annual Meeting, French Lick Sheraton Hotel, French Lick, Indiana
18-19	Kentucky Pediatric Society and Kentucky Chapter, American Academy of Pediatrics, joint annual meeting, Owensboro
25	KMA Twelfth Trustee District Meeting, Quality Court Motel, Somerset

JUNE

8	KMA Third Trustee District Meeting, Madisonville
14	KMA Sixth Trustee District, Bowling Green

IN SURROUNDING STATES

APRIL

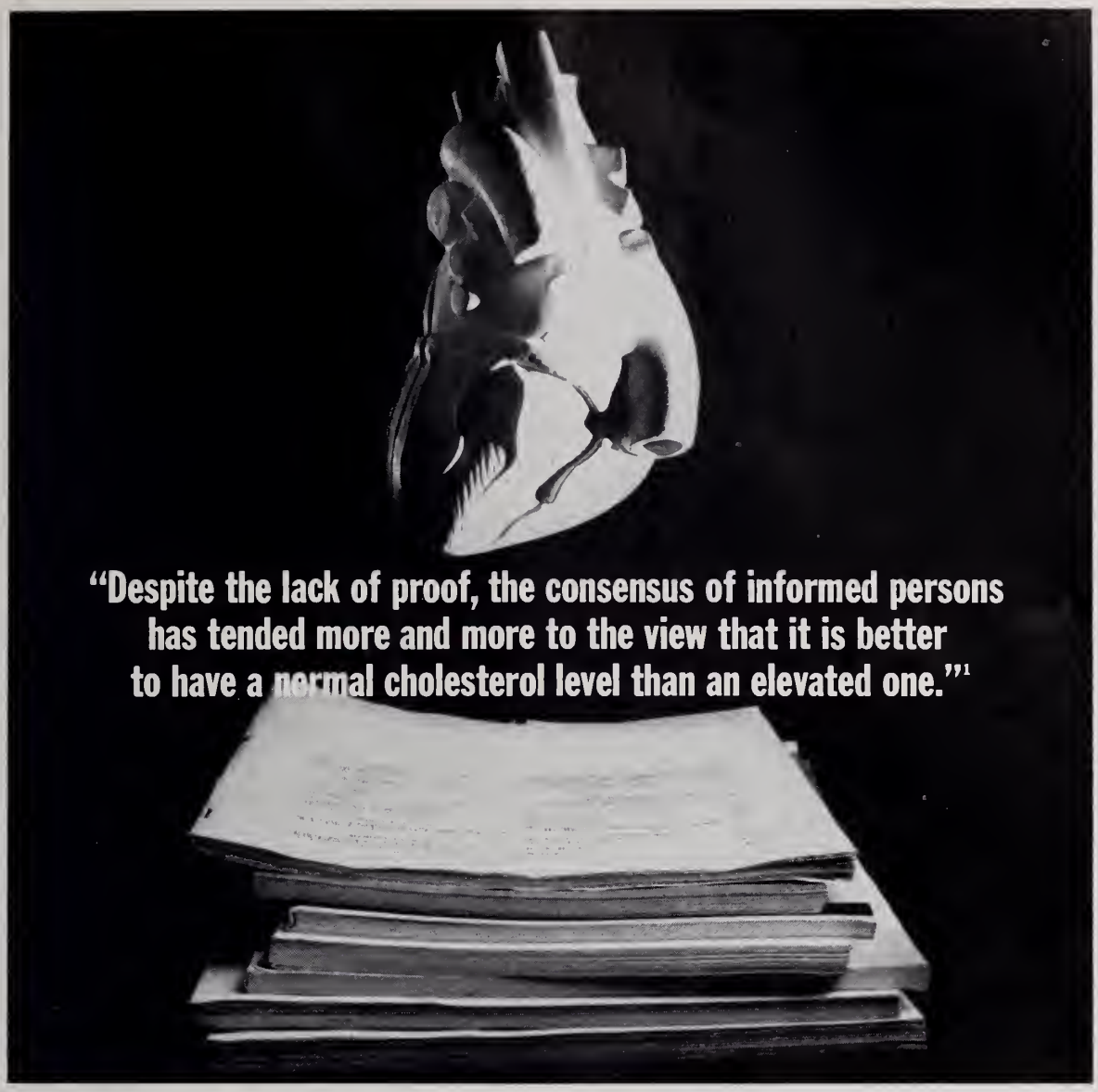
13-16	19th Annual Spring Meeting, West Virginia Academy of Ophthalmology and Otolaryngology, The Greenbrier, White Sulphur Springs, W.Va.
14-19	American Dermatological Association; at Hot Springs, Va.
15-17	American Society of Internal Medicine, New York City
16-17	18th Annual Joseph and Samual Freedman Lectures in Radiology, University of Cincinnati College of Medicine
17-19	Tennessee Medical Association Annual Meeting, Gatlinburg Auditorium, Gatlinburg
18-22	American College of Physicians Annual Meeting, New York City
25-28	American Industrial Health Conference; Sheraton Cadillac Hotel, Detroit
27-29	American Pediatric Society Annual Meeting; Seaside Hotel, Atlantic City
28-30	Third Annual Midwest Conference on Anesthesiology, Illinois Society of Anesthesiologists, Chicago

MAY

1-5	American College of Obstetricians and Gynecologists annual meeting, at Chicago
1-5	International College of Surgeons, U.S. Section, meeting at Houston
9-13	American Psychiatric Association annual meeting at Atlantic City
11	American Cancer Society, scientific session, St. Francis Hotel, San Francisco
11-15	Student American Medical Association annual meeting, Los Angeles
15-18	Illinois State Medical Society, Sherman House, Chicago
22-26	American Orthopaedic Association, Colorado Springs, Colo.
24-26	Ohio State Medical Association, Cleveland
26-28	American Gastroenterological Association, Drake Hotel, Chicago
30-June 1	American Ophthalmological Society, White Sulphur Springs, W. Va.

JUNE

2-4	American Gynecological Society, The Homestead, Hot Springs, Va.
26-30	AMERICAN MEDICAL ASSOCIATION Annual Convention, Palmer House and McCormick Place, Chicago



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IN THE BOOKS

GASTROENTEROLOGY, Vol. III, Second Edition: edited by Henry L. Bockus, M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1965; 1352 Pages; Price, $30.00.

This 1300 page book completes the thoroughly revised three-volume text of gastroenterology edited by Doctor H. L. Bockus. Major sections are devoted to intestinal parasites, to diseases of the liver, the pancreas, the gall bladder, and to the associated gastrointestinal disorders of systemic illness. This latter section is of particular value for its concise documentation of secondary gastrointestinal dysfunction in the broader aspects of internal medicine.

Each section is carefully edited to present basic pathophysiology with clinical correlation. Considerable attention is given to the newest diagnostic procedures and therapy is reasonably up-to-date. The book is enhanced by liberal use of reproductions many in color and by extensive bibliographies.

The magnitude of the book attests to the breadth of coverage and "in depth" treatment of the subject. Clarity and continuity of presentation is a tribute to the 44 contributing authors and to the skillful editing of Doctor Bockus. This book with its associated works will become the premiere reference text of gastroenterology for the family physician and specialist alike.

If there is a deficiency it will be the one of remaining current; a problem common to all medical texts due to the rapid advancement of medical knowledge. Nevertheless all practicing physicians will benefit by ready access to this book and its companion volumes.

JACK SCHAEFER, M.D.

DISEASES OF THE NEWBORN, Second Edition: by Alexander Schaffer, M.D., with Milton Markowitz, M.D., and Lawrence Finberg, M.D.; Published by W.B. Saunders Company, Philadelphia and London, 1965; 1023 Pages; Price, $22.00.

The Second Edition of Schaffer's *Diseases of the Newborn* is a welcome addition to the library of the resident, general practitioner, or pediatrician. Its need was justified by the advance of knowledge on neonatology, the incompleteness of standard texts of pediatrics, and because of some of the important omissions of the First Edition.

Again this well organized and informative book is largely the work of a single author, and is a testimony of his experience and success as a clinical pediatrician interested especially in the newborn. The pictures and case illustrations are excellent. "A picture is worth a thousand words" is most applicable to the photographs on the new pediatric syndromes which can be confirmed by chromosomal or biochemical studies.

The chapters on differential diagnosis will benefit many physicians in their appraisal of the problem infant and in referring them to correct diagnostic measures.

There are many who will not "have fond memories of sternal traction" in therapy for hyaline membrane disease. The use of sodium bicarbonate without acid-base and gas studies, e.g., 5mEq, mild; 10 mEq, moderate would be dangerous. Others will not recommend exchange transfusion for all prematures with only a positive Coombs test. Many would now urge early versus late feeding of prematures in light of recent knowledge. All physicians should now incorporate into their thinking and therapy the new principles of gastroenterology, e.g. disaccharidase and other enzyme activities and deficiencies, which are not mentioned. As can be expected of any text, new inborn errors of metabolism which have been diagnosed in the newborn were not mentioned, e.g. lysinemia, homocystinuria, etc.

The next edition may incorporate the use of subspecialists and be more complete but the present two editions by a single author with the courage to amass and organize his experience will continue to be a standard reference for all physicians who care for those who are shortly born and soon in trouble.

BILLY F. ANDREWS, M.D.

SYMPOSIUM ON THE LENS: (From articles appearing in the August 1965 issue of Investigative Ophthalmology): Chairman, John Harris; published by the C. V. Mosby Company, St. Louis, 1965; 368 Pages; Price, $18.50.

This book, as a symposium, is an attempt to correlate and give future direction to the vast amount of basic research which has concerned the crystalline lens of the eye over the past few years. The result is a collection of isolated pieces of research work in anatomy, embryology, cellular proliferation, and the biochemistry of metabolism. The different topics have been grouped as much as possible into related sections followed by general discussions, in a not-too-successful attempt at cohesiveness.

Some of the more interesting topics covered are those relating to the electron microscopy of the lens, the effect of aging in altering metabolic pathways in various animal lenses, and the immuno-chemistry of the lens. There is proof, for instance, that there is a partial block of glycolysis with aging and a shift in the relative importance of the aerobic and anaerobic

metabolic cycles. Another interesting fact, from a clinical point of view, is that in one series at least, "senile" cataracts were four to six times more common in diabetics over fifty than in the general population over fifty. This may eventually have some significance in relation to the several papers appearing in the book on the sugar metabolism of the lens.

In general this book is worthwhile as a reference work for basic researchers in ophthalmology and the basic sciences, because it does bring into one volume some of the more important basic research which has been done recently on the lens. It does not completely fulfill the hoped for purpose of providing a cohesive report on the present status of basic lens research. It is another step in the pathway to the eventual definition of the basic pathogenesis of the various types of cataract but is of little value to the present practitioner of ophthalmology.

ROBERT J. KAISER, M.D.

* * *

There exists an unrealistic public image of drugs that there could be remedial agents with various and optimum therapeutic effects without any toxicity. This is clearly utopian. The drug without side effects still remains to be discovered and it is most unlikely that it will ever be found.—Cornielle J. F. Heymans, M.D., in *Georgetown Medical Bulletin*, (18:174-175), February 1965.

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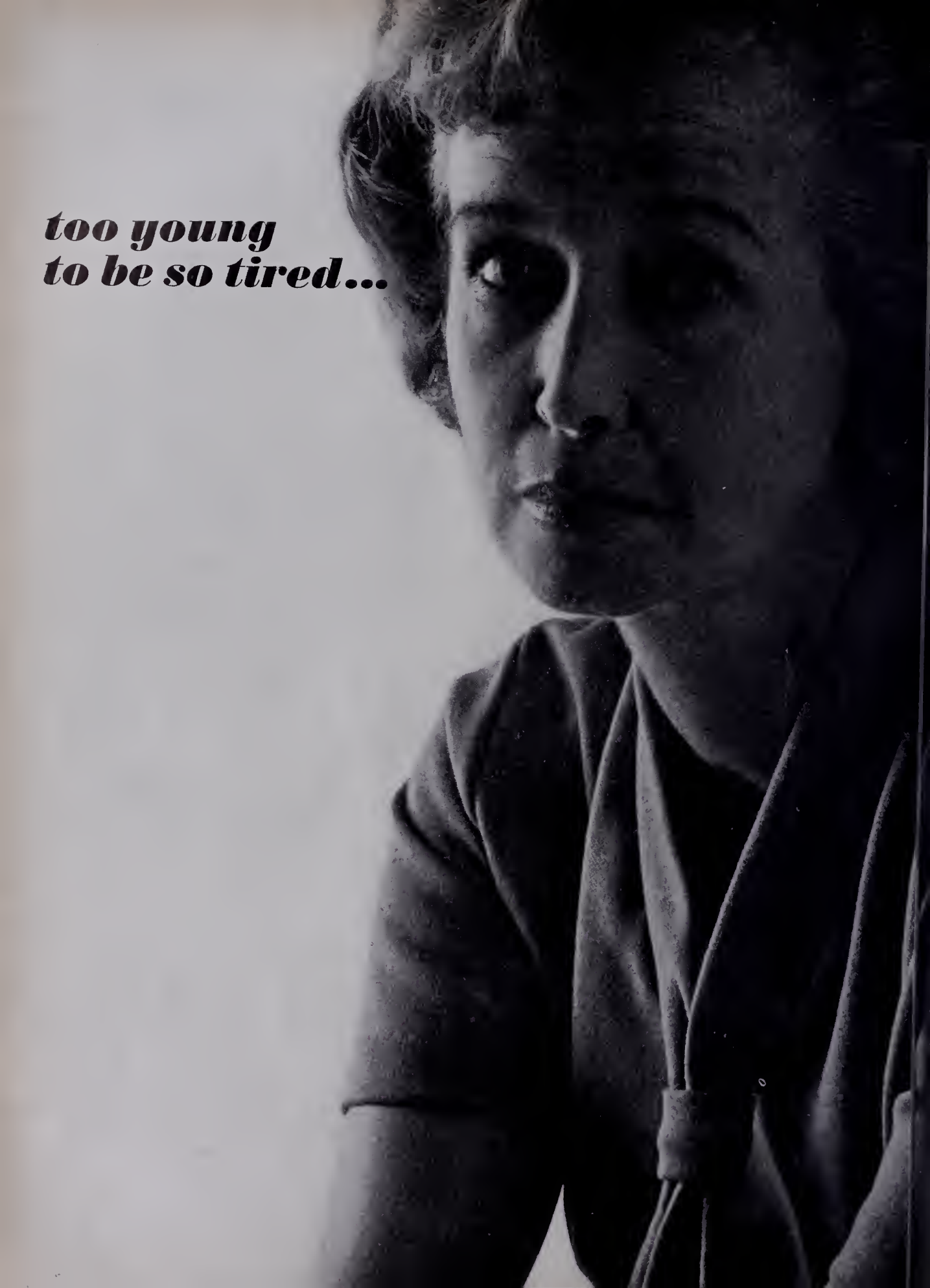
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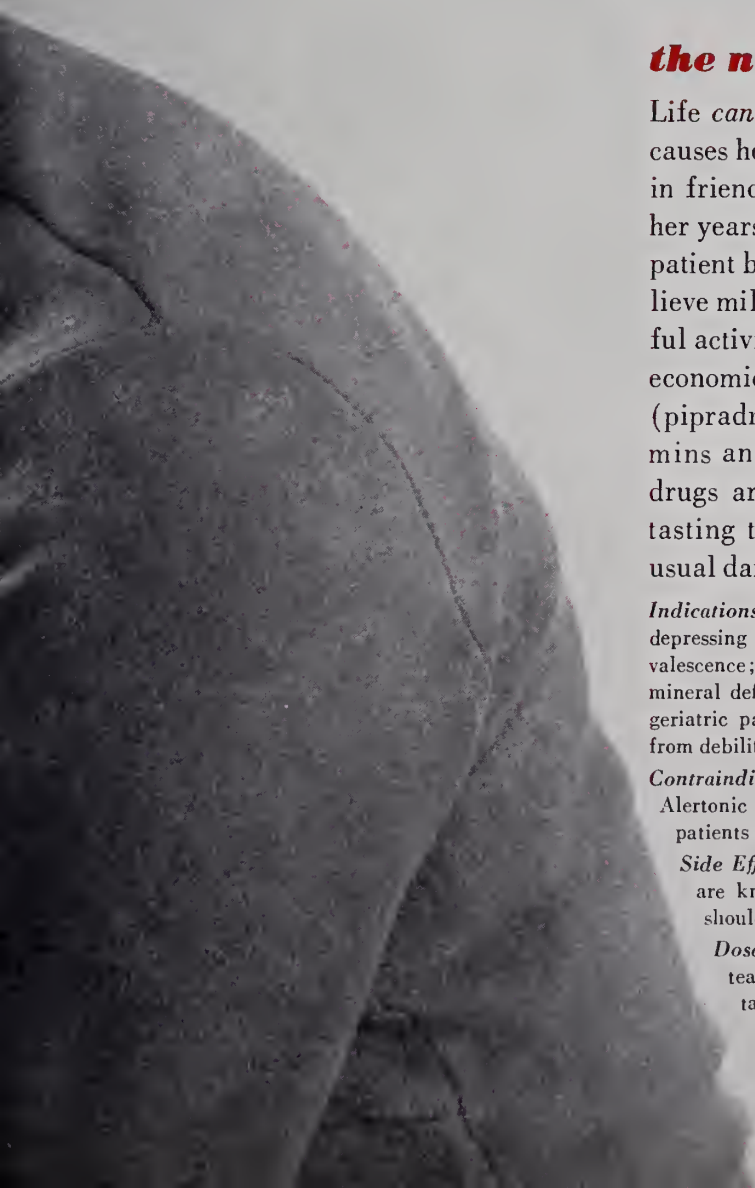
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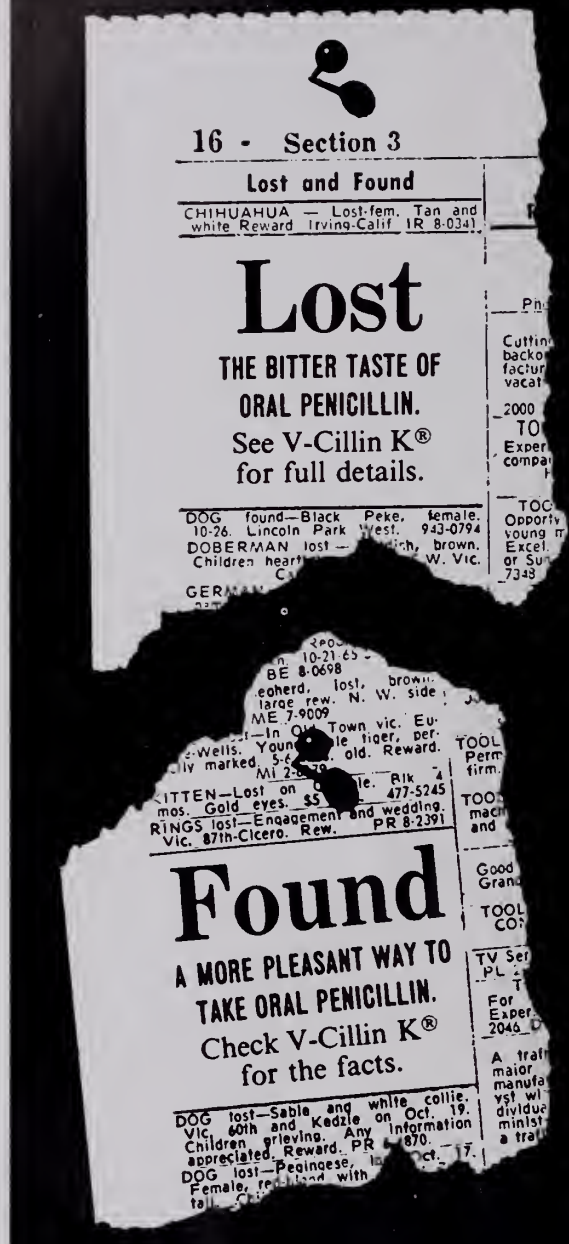
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The JOURNAL of the
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VOLUME 64 APRIL, 1966 No. 4

Epidemiologic Approaches and Problems in the Assessment of Causal Factors in Chronic Respiratory Disease†

Leonard M. Schuman, M.D.*
Minneapolis, Minn.

The epidemiologic method, though not devoid of complexities and not immune to biases of selection of case and control materials does provide a "natural" approach to the in situ study of causal factors in chronic respiratory disease, particularly when such causes may be multiple.

IT HAS become abundantly clear not only that the search for causative factors of chronic disease within our environment can be highly productive but that the epidemiologic approach can frequently obviate many of the problems inherent in attempting direct experimental approaches to causal relationships in disease. Although the results of animal experimentation may be highly useful in testing causal hypotheses, elaborating upon them, and providing clues to mechanisms of pathogenesis and causal relationships, positive findings in animals have no greater inherent right of transference as *direct* proof of human disease causation than do negative findings as proof against such a mechanism. Furthermore, direct experimentation will not only frequently remove the test subjects, animal or human, from the context of their natural environments, but will, at times, introduce new variables having profound influences on the outcome of the manipulation or, at best, obscuring the meanings of the observed results. This could be tantamount to removal or addition of as yet unknown factors in the environment having adjuvant, co-factorial or even synergistic influences. Even when human experimentation is morally acceptable, it may not always be practical. For example, to have tested the causal relationship of the smoking of cigarettes and lung cancer would have implied the random selection of very young subjects prior to the age when some of them would have begun to smoke and from environments which were as nearly identical as possible. Those who would be made to smoke—the test subjects—and those who would be kept from smoking—the controls—would be randomly allocated, their smoking and other habits would need to be held constant for many years and the environments otherwise held identical for both groups. Because lung cancer incidence is relatively low in a population, both test and control groups would have to be extremely large. The impracticality of such an experiment is immediately obvious.

The epidemiologic approach, on the other hand, examines the interrelationships of en-

†*Presented at the Fourth General Session of the Kentucky Medical Association Annual Meeting September 21-23, 1965.*
**Professor of Epidemiology, University of Minnesota School of Public Health, Minneapolis, Minn.*

vironmental and host factors and the occurrence of disease in populations without disturbing their true relationships and relative weights. It examines disease in situ, as it were. It attempts to interpret the results of complex experiments performed by nature or, inadvertently, by man. The very definition of epidemiology dictates that this shall be so.

Growth and Usefulness of Method

The last 50 years has seen an exponential growth in the application of the epidemiologic method to the study of the chronic diseases. The yield in the causal nature of relationships of environmental factors in chronic disease has been so great as to vindicate the applicability of principles derived from the epidemiologic study of the acute infectious diseases. Since the concept of cause embraces both the presence *and* absence of substances or conditions which are conducive to the occurrence of disease, it is not improper to mention the epidemiologic studies of Goldberger establishing pellagra as a deficiency disease. This was probably one of the earliest, if not the earliest, of the epidemiologic studies directed toward ferreting out an environmental cause of a chronic disease. At the risk of failing to give properly high priority to other worthy studies there may be cited those which have helped to establish the causal relationship of inhaling cigarette smoke to lung cancer, chronic bronchitis and laryngeal cancer; of exposure to chromates and nickel in industry to lung cancer; of high-energy radiation, as in the Hiroshima blast, to leukemia; of chronic exposure to X-radiation to leukemia in medical practitioners in general and radiologists in particular; of diagnostic and therapeutic X-radiation to leukemia in childhood; and of radionuclide exposure in hard-rock uranium mines to lung cancer.

The epidemiologic method is particularly useful where the presence of a given agent does not always produce disease in the exposed, since other environmental and intrinsic host factors (such as genetic susceptibility) may modify the intensity of the response to that agent. The method is also highly useful in the study of a disease which may be caused by more than one agent. If there were but a single cause for every disease and a one-to-one relationship between a factor and the disease, e.g. every case of chronic bronchitis reveals a history of exposure to nitrogen-dioxide and every person exposed to nitrogen-dioxide develops chronic bronchitis, there would not be a need for either experiments or for advanced epidemiologic approaches to determine causality. The fact would have been apparent almost immediately that exposure to nitrogen-dioxide was both necessary and sufficient, and hence a cause, would have been self-evident. However, for most if not all diseases, causes are multiple or, at least, environmental and/or host factors fortunately modify the response of the host so that not all exposures lead to the disease or the same severity of the disease. Thus, for the most part, no one case of illness can establish a causally meaningful association with a host or environmental characteristic. The person working in a lead factory develops pulmonary fibrosis and cor pulmonale. This is no more proof of the association between lead and pulmonary fibrosis than that between arsenic and pregnancy for the female who works in an insecticide factory and becomes pregnant. (We must keep in mind that this is quite different from a *judgement* on what is the most likely cause operating in a given case of a disease for which several causal factors have already been delineated.) Only reasonably large groups of cases in their natural environment can provide us with the necessary information.

Approaches to Study

Among the earliest approaches to the study of environmental factors (and for that matter, host factors, as well) which the epidemiologist utilizes is a scrutiny of vital statistics data on mortality or morbidity from the disease in question, with respect to certain characteristics. This may include secular or long-range or seasonal cycling; predilection for certain age groups, one sex or the other, certain occupational or socioeconomic groups; or concentrations of cases geographically or by race. These concentrations may provide clues to certain environmental differences as climate, food supplies, dietary habits or patterns, sanitation, toxic exposures in industry, air pollution or background radiation to account for differences in exposure or risk. Seasonal and particularly, secular trends may be associated with a concomitantly increasing or decreasing factor (more realistically in the environment than in the host). Statistically significant associations derived thereby become the bases

upon which hypotheses with biological meaningfulness are constructed. With the elaboration of an hypothesis more detailed epidemiologic studies are designed to provide support for the hypothesis or to carry it to more detailed and refined meanings.

More or less refined hypotheses demand more formal epidemiologic approaches. These can be in the form of retrospective or prospective studies (or their combination). These are both population studies and each is dependent upon individual case history data. The retrospective study concerns itself with a group of cases of a disease which is compared with a properly selected group of persons without the disease (controls) in respect to the proportion of individuals in each group who have characteristic deemed to be a possible etiologic factor. If the group of cases has a statistically significantly higher percentage of the factor than the control group, the factor is said to be associated.

The prospective study concerns itself with a selected population divided according to the presence or absence of a characteristic deemed to be a possible causal factor and the subgroups followed for the development of the disease in question over a definite period of time. If the group with the factor has a significantly higher risk of developing the disease than the group without the factor, the factor is said to be statistically associated.

Each of these methods has its respective advantages and disadvantages and, although obviating many of the practical problems inherent in direct experimentation, poses certain generic problems which will have to be overcome methodologically. The chronic diseases in general (and the chronic bronchopulmonary diseases are no exception) have several characteristics which add to the difficulty of investigation of causal factors. Two of these characteristics are their prolonged latent or induction periods and the insidious onset of signs and symptoms.

Influence of Character of Onset on Method

It is not always clear whether the length of the induction period reflects the slow accumulation of effects from repeated or continuous low-dose assaults, whether it represents the time necessary for the developing pathologic process to cross the threshold of observation, or both. Although the length of the induction period is not known for most of the chronic, degenerative diseases, where research has implicated causal or contributory factors in the production of certain of these disease, the factors have been found to have acted or begun to act on the individual a number of years earlier. Observations leading to precise knowledge of induction periods have been infrequent. It is a rare opportunity to associate a dramatic event such as the Hiroshima bomb with the peak development of excess leukemia cases in the exposed population seven years later. From such observations as have been made it is assumed that most, if not all, chronic (non-infectious) disease have induction periods which are measured in years.

With induction periods of such length, antecedent causal factors, be they environmental or intrinsic, may be obscured by time (if they are such that one insult is sufficient to trigger the disease process) or be overlooked because they are common and continuing in time. When a biologically-reasonable hunch or theory proposes an environmental factor, custom or habit in the past as a cause and the factor either requires quantitation in broad terms only or is a continuing one with little variation over the years, the retrospective approach requiring recall can frequently be depended on as sufficiently reliable. Such was the case with the many retrospective studies linking cigarette smoking with lung cancer and chronic bronchitis. Smoking, the environmental factor, was reliably quantitated by the subjects not only because the question did not demand precision to within a cigarette or two, but also because the habit becomes stabilized in quantity, frequency and degree of inhalation quite rapidly for the vast majority of subjects.

This approach, however, is not practical when the suspected environmental factor fluctuates widely in time and its precise measurement is necessary to the association. This would be the case in an attempt to associate air pollution and chronic bronchopulmonary disease. It is true that such episodes as the Donora and London smogs provided strong evidence for the association of heavy smogs with relatively sudden mortality among cases of cardio-respiratory illness, but the lack, then, of air-monitoring programs made it impossible to determine which elements of the smog were, in truth, responsible. It is also obvious that,

in the type of situation calling for an exploration of the role of air pollution in the *production* of chronic bronchopulmonary disease, the subject can have no knowledge of either the quality or quantity of air contaminants in the community. This is generalized air pollution and not the local pollution of tobacco smoking. It is even more generalized and more subtle than the intermediate type of air pollution encountered in the immediate vicinity of certain industrial processes. A proper epidemiologic approach would be the more formidable and expensive prospective study with monitoring of the air of several communities with contrasting amounts of pollution and comparing their experiences in the development of bronchopulmonary (or other) disease. The same principle would apply to a study of the role of radioactive fallout in the production of, for example, congenital malformations.

Complexity of the Problem

The last two statements run the risk of deluding the reader. Their brevity belies the agonies inherent in their execution. Nothing has been said about separating the various contaminating compounds and the extent to which monitoring of all of these compounds is practical; nothing has been said about the length of time the study shall run nor the cohort selection; nothing has been said about the problem of varying rates of in-and-out migration of the several populations, factors which obviously influence results.

Thus far, emphasis has been placed on the problem of selection of factors in the environment for study when, because of long induction periods, such factors may have operated remotely in time or continuously with low-dose impact. The second characteristic of chronic bronchopulmonary disease, mentioned earlier, also contributes materially to the complexity of the problem. The insidious character of onset of a disease may obscure the meaning of an antecedent event even when the induction period is short. For example, in nitrogen-dioxide exposure in silos or chemical laboratories, the insidious onset of bronchiolitis fibrosa obliterans may lead to failure of recall of an otherwise inocuous exposure which occurred three to four weeks previously. Furthermore, the insidious onset of many chronic diseases adds to the breadth of their spectra so that at any given point in time the selection of diagnosed cases yields a severity-biased sample. This obviously adds to the problems of a retrospective study for the controls may be loaded with a significant number of mild, as-yet-unrecognized cases. In a number of cross-sectional or retrospective studies of pulmonary disease large random populations have been selected and queried as to symptoms and/or examined by Vitalor and X-ray before dichotomizing that population into illness groups and controls. This latter approach merges subtly into the techniques of the prospective study where case selection is not an initial necessary step, but in which disease or symptom definitions and careful follow-up with minimal non-response attrition are essential.

The extreme breadth of the spectrum of many of the chronic diseases aggravates the problem of establishing associations with suspected causal factors, particularly in prospective studies. If mortality per se is the end point, the problem is minimal for all deaths are recorded. If morbidity is the end point, diagnostic problems immediately appear. In a study of pulmonary emphysema one may not tally only those severe cases coming to medical care, but must make provision for X-ray diagnoses irrespective of symptoms, since thresholds of discomfort vary as much as they do. In chronic bronchitis, definitions become extremely important in view of the diversity of opinion as to what constitutes chronic bronchitis, particularly among several nations. In fact, because of the problems of definition and the breadth of the spectrum, epidemiologists have been given more and more to the study of reliable symptoms such as chronic cough, sputum production, shortness of breath on specifically described exertions and of signs, such as total and one-second vital capacities, rather than attempt final diagnoses of chronic bronchitis and the like. The yield of new information has been rewarding.

The presentation of methodologic problems encountered in the application of epidemiologic techniques for the elucidation of causal factors in chronic disease is not intended to inject any note of pessimism for this approach. In fact, the modern epidemiologist must remain constantly aware of the pitfalls in order that the elicited associations may be deemed real. It is the reality of the elucidated associations that is frequently the target of much sniping.

Epidemiologic studies short of direct experimentation with human population groups have been stigmatized by some—usually those with a vested axe to grind—as "only statistical". Such individuals fail first of all to realize that the occurrence of any event is a statistic, that the measurement of variations in observations involves statistics, that a physician's diagnosis most often is a judgement based on the probability or likelihood that a certain combination of signs and symptoms spell a certain disease. Such individuals fail secondly to realize that causality and its "proof," in the strictest sense, is an elusive mistress, a philosophic will-o-the-wisp, for even in an experiment must a judgement be made that its outcome is the effect of the manipulation applied. It is for this reason that the laboratory experimenter not only replicates his observations but constantly seeks for confounding variables or interfering influences which may at least modify, if not produce, the results observed.

Critical Evaluation

No self-respecting epidemiologist would on the same basis, deem an association to be a causal relationship on observing such an association for the first time. Statistical methods cannot establish proof of a causal relationship in an association for either the experimenter in the laboratory or the epidemiologist in the field. The causal significance of an association is also a matter of judgement which goes beyond any statement of statistical probability. The epidemiologist must indulge in an intensive critical evaluation of the association. No single criterion will suffice for a judgement of causality. Is the association real? Are the cases and controls representative of the population for which inferences are to be drawn? Do biases of selection and observation exist? Do the degrees of bias seriously impair the inferences?

Is the association consistent in that the majority if not all of the studies reveal the same association? What is the strength of the association in terms of the risk of the disease among those with the characteristic or exposed to the factor under study as compared to the risk among those without or not exposed? (The higher the relative risk ratio the more likely the association is causal.)

Is the association specific? Here the relative risk ratio is also helpful in determining whether the factor under test is of major or minor importance in the total picture of causality. A high risk ratio may imply the former whereas a low relative risk ratio may indicate other factors are also causal.

Is the temporal relationship between the characteristic or factor and the onset of the disease of proper order i.e. is the factor, suspected to be causal, antecedent in time to the disease ?

And finally is the association coherent with the known facts in the natural history and the biology of the disease? Here the biologic meaningfullness of the association comes into play as well. A causal hypothesis is easier to accept if it makes biologic sense; for example, the inhalation of cigarette smoke does bring the suspected agent or agents to the tissues involved in lung cancer, chronic bronchitis, laryngeal cancer, and emphysema. In this instance the dose response is important for, if causally related, the effect should increase in magnitude as the factor increases in strength. Although the production of the lesion in animals does not constitute definitive proof, since it is dangerous to extrapolate from one species to another, nevertheless, such a demonstration serves a dual purpose: It increases the biologic reasonableness of a causal inference from the association and it provides a model from which biologic mechanisms may be elicited and sought for in man. Furthermore, alternative hypotheses must be scrutinized to determine whether the biologic facts and epidemiologic features of the disease fit these better.

Finally, the causal hypothesis must be coherent with the other epidemiologic features of the disease and the characteristic under test. If a factor is to be deemed causal for a given disease and it is present in greater proportion in a given population segment, then, all else being equal, that segment should have a higher frequency of the disease and vice versa.

Thus, a collective appraisal of these several criteria is mandatory for a judgement of causal significance in an association.

It has been noted earlier that the yield of causal environmental factors via the epidemiologic approach has been gratifying. In particular, the conviction with which we can now accept the relationship between smoking and

certain bronchopulmonary diseases makes it mandatory to correct for this now confounding variable in all explorations of other environmental factors whether it be community air pollution or localized occupational pollution. It is my opinion that, although cigarette smoking has been shown to account for the vast bulk of such diseases as lung cancer and chronic bronchitis, the "non-smoker residuals" of these and other bronchopulmonary diseases will have to be explored in terms of atmospheric pollution. Such studies will be primarily epidemiologic in character for such relationships must be studied in intact populations. They will be complex; they will be expensive; they will take long periods of time, for replications will be necessary to determine the realness and consistency of any determined associations. Because some entities, like cor pulmonale, are not common garden varieties of disease, intercommunity cooperative research will become even more important. My faith in this approach has been reaffirmed recently by the findings of our cooperative leukemia study in which all the cases of leukemia occurring in a three-year period in the metropolitan areas of Minneapolis-St. Paul, Baltimore and Upstate New York had to be pooled in order to study a significant number of factors in an environmental hypothesis.

One final comment is in order. Little has been said about additive or synergistic effects of several environmental factors in chronic bronchopulmonary disease. Although the epidemiologic evidence in the United States indicates the predominant role of cigarette smoking in chronic respiratory disease, in the United Kingdom disabling respiratory conditions and death occur more frequently among those who smoke cigarettes and are exposed frequently to atmospheric pollution than in those exposed to either alone. The need for exploration in depth in this area is obvious. Approaches to this problem are in their infancy but are being made. They offer additional promise in ferreting out other causal factors and their interactions in chronic pulmonary disease.

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Vascular Injuries of the Upper Extremity

Morton L. Kasdan, M.D.* and Harold E. Kleinert, M.D.**

Louisville, Ky.

Management of upper extremity vascular injuries is briefly presented. The results obtained in 104 cases, including 17 cases of arterial injury resulting in "non-viable" extremities distal to the wound, are reviewed.

DURING THE past six years, we have had opportunity to treat 104 patients with arterial injuries of the upper extremity. Anastomotic thrombosis of small vessels stimulated us to evaluate these cases.

At the time of World War II, peripheral vessel injuries were treated mainly by ligation, resulting in a high incidence of amputation.[3] The nearly or completely amputated extremity can be salvaged if cellular necrosis has not occurred from local tissue trauma or from excessive lapse of time, and if the circulation can be restored.[2,8,9,10] Technical advances in vascular surgery have now made possible the successful anastomosis of small blood vessels. The problem of thrombosis in vessels measuring less than 3 mm. remains.[4,5,6,7,12,13,14,15,16]

TABLE I

SUMMARY OF CASES

Injuries	Cases	Repair	Ligated
One artery	95	52	43
Two arteries	9	8	1
Total	104	60	44

From August, 1958 to August 1964, 104 patients were admitted with arterial injuries of the upper extremity (Table I and Table V). We excluded numerous cases of digital vessel trauma and cases of superficial volar arch ligation.

Seventeen cases had "non-viable" extremities distal to the wound, as manifested by pallor, mottling, coolness, and the lack of retrograde bleeding from the distal wound surface.

Patients with severe injuries were evaluated quickly in the emergency room then transferred to the operating room. Many of these cases had significant blood loss and had varying levels of shock. Hemorrhage was controlled by direct pressure. Intravenous fluids were started with a large gauge needle in the uninjured extremity. Axillary block anesthesia was used for most cases with wounds distal to the lower humerus.[1,11] General anesthesia was employed for the cases with more proximally located wounds.

The tourniquet was not employed during the period of arterial repair. Considerable time was devoted to cleaning and irrigating the wounded extremity. Stabilization of bone was completed prior to vascular repair. Fine vascular bulldogs were applied 1 to 2 cms. from the site of injury. Adventitia and fractured intima was carefully debrided (Figure 1). Heparin solution was injected proximally

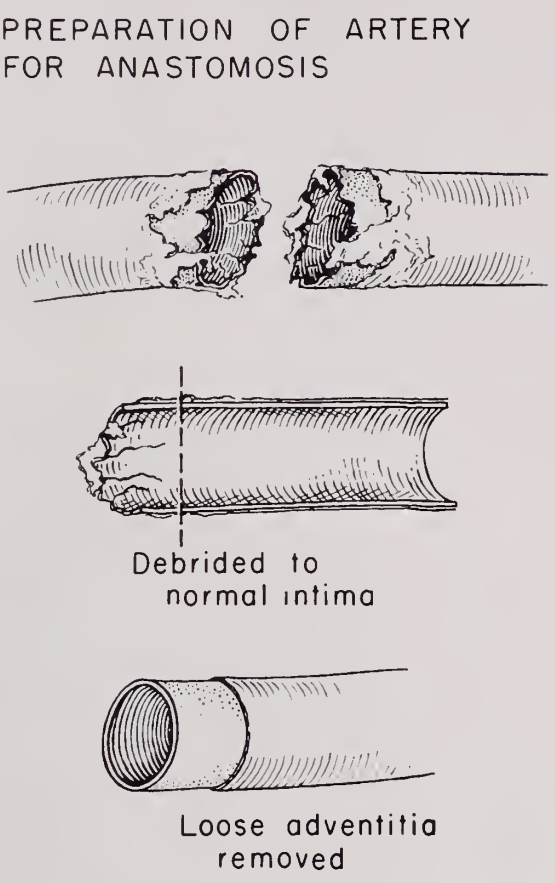
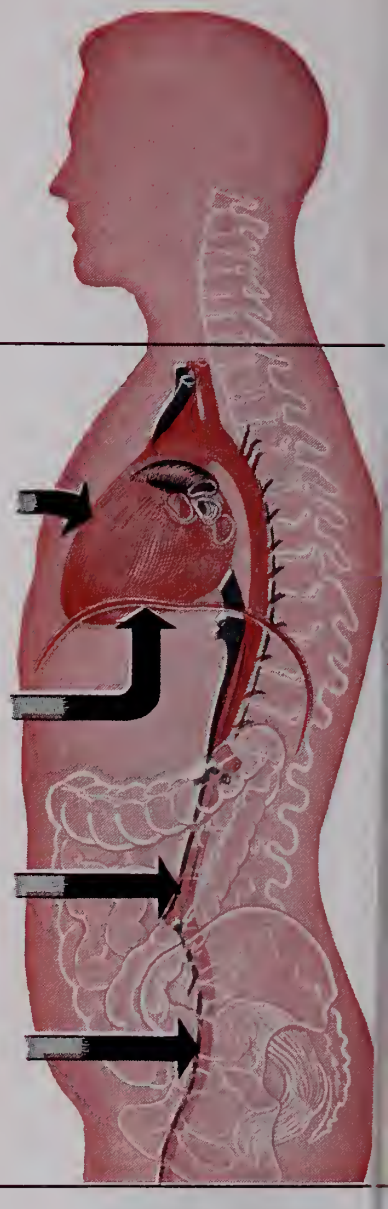


FIGURE 1. Injured artery debrided to normal intima. Loose adventitia is meticulously removed prior to repair.[9]

*Surgical resident, University of Louisville Hospitals.
**Clinical associate professor of surgery, University of Louisville School of Medicine.



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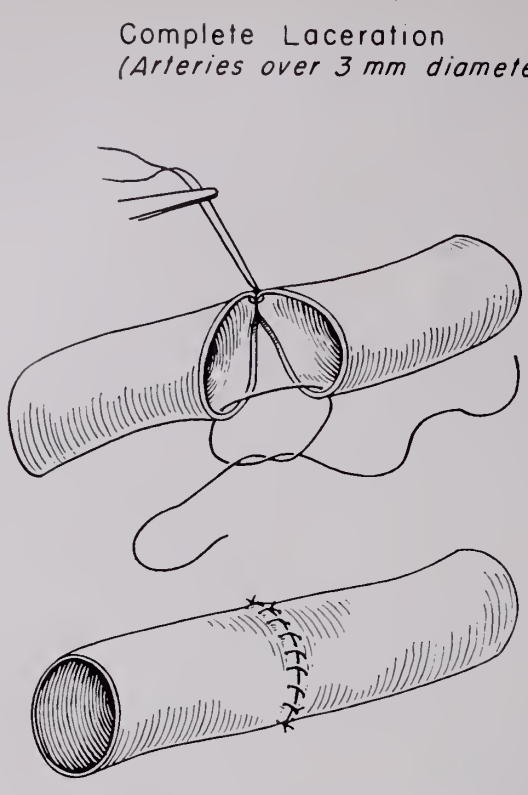


FIGURE 2. Complete lacerations of arteries 3mm. or more in diameter are repaired with a running cardiovascular suture after stay sutures have been introduced.[8]

and distally. Clots were milked from the vessel. Patency of the vessel was established prior to the anastomosis and a retrograde heparin flush utilized if necessary.

The repair was constructed to prevent even minimal narrowing and rotation. Stay sutures were placed at equidistant points in the circumference of the vessel (Figure 2). Vessels 3 mm. or smaller were repaired with fine vascular sutures on an atraumatic needle. A synthetic suture (Dacron, Tefdac, etc.) was preferred. Stricture of small vessels with longitudinal wounds can be minimized by applying a patch graft. "Fish mouth" incisions were made in transverse lacerations to increase the diameter at the anastomosis (Figure 3). Grafts were employed to avoid anastomosis under tension (Figure 4). Venous autografts were used for restoring continuity of vessels which might otherwise be under tension (Figure 5).[8,9]

Eighty-seven of the 104 cases were considered as having a viable extremity distal to the site of trauma. Of these, the artery was ligated in 44 and repaired in 60 (Table I). Indications for anastomosis of the severed noncritical vessel were: impaired distal circulation or the

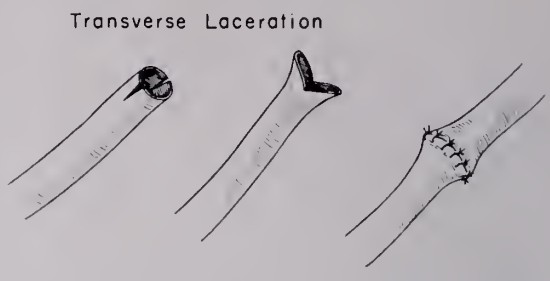


FIGURE 3. Transverse lacerations of arteries 3mm. or smaller in diameter are anastomosed after a "fish mouth" incision has been made to increase the diameter of the anastomosis.[8]

TABLE II

Injuries	ARTERIES INJURED Repaired	Ligated	Amputated
Radial	11	22	0
Ulnar	15	20	0
Radial & Ulnar	8	1	1
Brachial	16	1	0
Axillary	7	0	1
Superficial Volar Arch	3	0	0
Total	60	44	2

injured vessel appearing larger than the intact radial or ulnar artery.

Seventeen of the 104 patients were considered to have a "non-viable" extremity (Table III). Arterial repair was done in sixteen and venous repair in six. Six patients had both radial and ulnar arteries divided. Arterial repair was done in five and primary amputation in one (a child with bilateral forearm amputations) (Tables II and IV).

Six of the patients with "non-viable" extremities were given systemic anticoagulants. All 16 patients received one or more stellate ganglion blocks to minimize vasospasm. Patients with severe pain had axillary blocks of the brachial plexus (Figure 6). It is simple,

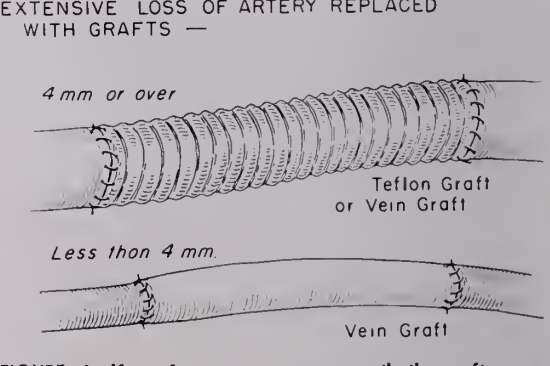
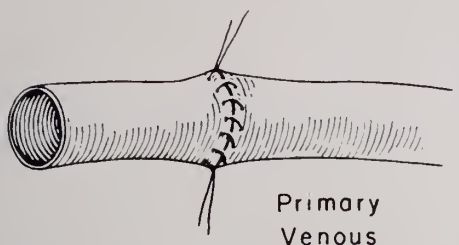


FIGURE 4. If grafts are necessary, synthetic grafts may be employed for larger arteries. (Axillary). Smaller arteries, including brachial, are restored with vein graft.[9]

IF EXTREMITY IS SEVERED, OR NEARLY SEVERED, VENOUS FLOW MUST BE RESTORED.



Where extensive damage has occurred venous flow is re-established with vein grafts.



FIGURE 5. Venous flow must be restored in amputated or nearly amputated extremities. If a graft is necessary, vein is utilized.[9]

safe, and relieves pain as well as vasospasm for as long as eight hours.[1, 11]

The largest percentage of cases (46%) were injured by broken glass. (Table V). Eighty-one patients had completely transected arteries. Patients with incomplete arterial lacerations lost a greater volume of blood. The age distribution is demonstrated in Table VI.

Atrophy to some degree was noted in all cases originally thought to have a non-viable extremity. Atrophy and pain were occasionally noted when a noncritical vessel was ligated. Several patients complained of mild pain and cold intolerance. Patients with repaired "non-critical" arteries initially had greater cold tolerance than patients who had a similar artery ligated. After ligation, in some cases followed over a three year period, cold tolerance did improve as collateral circulation developed.

TABLE III

NONVIABLE EXTREMITIES PRIOR TO SURGERY

Artery	Case considered nonviable		Result
Axillary	5	4 good	1 secondary amputation
Brachial	6	5 good	1 fair (poor function)
Radial & Ulnar	6	5 good	1 primary amputation
Total	17		



FIGURE 6. Axillary block anesthesia for upper extremity surgery is simple and can relieve pain as well as vasospasm for as long as eight hours.[11]

TABLE IV

DISTAL PULSE RESTORED BY REPAIR

Injured Artery	Yes	No	Questionable
Ulnar	15	2	4
Radial	19	1	1
Brachial	13	1	2
Axillary	6	1	0
Superficial volar arch	3	0	0

TABLE V

ETIOLOGY OF LACERATED ARTERIES

Offending Agent	Cases	Type Injury Complete	Incomplete	Thrombosis
Glass	48	42	6	0
Knife	16	12	4	0
Bullet	12	6	6	0
Shotgun	4	2	1	1
Blunt trauma	4	2	0	2
Power Mower	2	2	0	0
Saw	3	2	1	0
Unknown	13	11	2	0
Trains	2	2	0	0
Total	104	81	20	3

TABLE VI

AGE DISTRIBUTION

Age	Number of Cases
1 - 10	19
11 - 20	13
21 - 30	22
31 - 40	25
41 - 50	10
51 - 60	8
61 - 70	4
71 - 80	3
Total	104

Summary

1. One hundred and four cases of arterial injuries of the upper extremity are reviewed. Sixty cases were treated by repair and forty-four cases by ligation.

2. Seventeen patients were evaluated as having a devascularized extremity distal to the wound. Fourteen obtained viable functioning hands.

3. Radial and ulnar arteries should be an-

(Continued on Page 354)

As Seen by the Ophthalmologist and Otolaryngologist†

Thomas M. Marshall, M.D.*
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Disturbance of vision, hearing, smelling and swallowing are symptoms which sometimes occur early in the course of a brain tumor. This is an attempt to review some of the signs and symptoms which suggest the presence of a brain tumor.

CERTAIN tumors of the brain are more likely to come first to the attention of certain medical specialists. The patient with a pituitary adenoma commonly first consults the ophthalmologist. Many of the patients with tumors of the brain stem first come to the attention of men who concentrate on disorders of the eye, because so many of these patients develop disturbance of their ocular movements early in the course of their disease. The patient with an acoustic neuroma is usually first seen by the otologist.

In order to evaluate the ocular signs and symptoms in brain tumor cases, a series of brain tumors that presented first to the ophthalmologist in practice was collected by O'Rourke and Schlezinger.[8] Almost 80 per cent of the 100 brain tumors in this series were of five types: Pituitary tumors, meningiomas, cerebellar gliomas, metastatic carcinomas of the nasopharynx and acoustic neuromas. Sixty per cent of all these tumors were associated with the parasellar area. Papilledema was present in 42 per cent of the patients and 58 per cent showed optic atrophy. Visual field defects were found in 69 per cent of the cases. Although headache was common in this series of cases, subjective impairment of vision, either intermittent or progressive was the symptom that most often caused the patient to come to the ophthalmologist. More than half of the patients showed an objective loss of vision below the level of 6/60 in either eye. This leads to the conclusion that in many patients, rather severe impairment is tolerated when it develops unilaterally and gradually. There was no single sign or symptom common to all types of brain tumors in this series.

†*Presented at the September 30 meeting of the Kentucky EEN&T Society during the 1964 KMA Annual Meeting in Louisville.*
**Clinical assistant professor of neurological surgery at the University of Louisville School of Medicine.*

Loss of Vision

It is exceptional for a pituitary tumor to be diagnosed or even suspected before it is sufficiently large to implicate the visual pathway and particularly the optic chiasm. The earliest perimetric evidence of tumor extending up from below the chiasm is depression in the upper temporal quadrants, demonstrable with small targets on the tangent screen. The characteristic change in the visual fields resulting from this chiasmal lesion, is a bitemporal hemianopsia with interruption being primarily in the crossing fibers of the chiasm. Variations in this general picture of bitemporal loss are produced by additional involvement of the optic nerves or tracts. Should the tumor extend forward and involve one optic nerve, it would likely produce a central scotoma in the field on the same side as that of the effected nerve. Should the tumor extend to one side, it may involve the ipsilateral optic nerve and tract producing thereby a central scotoma in the field on the same side as that of the lesion and a contralateral incongruous hemianopsia. It is to the discredit of ophthalmology that a considerable number of patients, who have suffered loss of vision as result of pituitary tumor receive no more specific treatment than several changes of glasses, some attention to the sinuses and a course of vitamin therapy before their perimetric fields are plotted, and the true cause of their visual

loss is recognized. It is the more regrettable because in the presence of this type of lesion, radiation therapy and especially surgery offer a good chance of preserving or even improving vision.[11]

From a clinical viewpoint, most patients with a pituitary tumor exhibit some pallor of the optic discs, its intensity being governed by the amount and duration of the visual loss. There is much individual variation. Pallor has definite value in prognosis, nevertheless. When the nerve heads are pink, even if visual loss has existed for many months, there is a good chance for improvement in visual fields and even a return to normal, following eradication of the tumor. When the nerve heads are slightly pale and the visual loss is relatively great, improvement may be expected and perhaps even a slight lessening of the pallor. When the nerve heads are distinctly pale, improvement in vision is not to be expected, although partial return is noted occasionally. When the discs are pale and in addition there is visible loss of nerve substance, then true optic atrophy exists and there is little possibility of recovery of any vision or of diminution of the pallor of the discs. Papilledema very seldom occurs in cases of pituitary tumor. When it does, it is a late finding and indicates the invasion of the 3rd ventricle. Paralysis of the extraocular muscles is infrequent in adenoma of the pituitary.[11]

Ophthalmologists should be equally interested in meningiomas because of their relative frequency of occurrence in the region of the sella turcica. Meningiomas in the parasellar, subfrontal and suprasellar regions tend to produce symptoms that include optic atrophy associated with a visual field defect of either the prechiasmal or chiasmal type. Defects in the visual fields limited to one eye are of necessity caused by a prechiasmal lesion. Such defective areas are often scotomata. The nasal and temporal fibers of the optic nerve in its intracranial course immediately in front of the chiasm are separated by a fibrous septum and this permits interruption of one set of fibers without disturbance of the others. Thus a lesion in this area may produce a temporal or a nasal anopsia with straight splitting down the midline in one eye. Any field defect in one eye, which has a midline vertical split must be due to a prechiasmal lesion[10] Routine roentgen examination of the skull to detect exostosis or erosion in the case of meningiomas and an enlargement of the sella in the case of pituitary tumors is most helpful.

Lesions which interrupt the visual pathways behind the optic chiasm produce field defects that are homonymous. Complete homonymous hemianopsia has lateralizing value only. It gives no information as to whether the difficulty lies in the tract or the optic radiation. Incomplete homonymous hemianopsia supplies more specific information. A congruous loss or a field defect which is similar in the two eyes, implies that the lesion is situated in the posterior part of the radiation, for here fiber bundles from corresponding parts of the two retinae lie close together. Such a defect is seen in occipital lobe tumors. Tumors that interrupt the radiation anteriorly, produce distortions that are slightly dissimilar in the two eyes and lesions that interrupt the optic tracts cause incongruous homonymous defects that are dissimilar. This occurs because the fibers from corresponding points on the two retinae are projected on the identical areas of the visual cortex but they do not pursue exactly the same course in getting to the cortex. Lesions of the temporal lobe are likely to produce quadrantal defects which extend to the point of fixation without macular sparing. They tend to produce defects in the visual field that are somewhat dissimilar in the two eyes, if the lesion is in the anterior temporal lobe. Posterior temporal lobe defects are usually quite congrous but are without macular sparing.[10]

Occasionally one encounters various types of disordered visual perception which are auras of symptomatic epilepsy. The "Deja va" phenomena, in which everything is normal in size, shape, distance and recognition but acquires an altered significance such as the patient's stating that he could not look away from an object that he was looking at or the sensation that he is seeing something that he had seen before and knew what was going to happen next although he was actually seeing it for the first time may occur prior to a generalized convulsive seizure. This type of phenomenon suggests altered function in the temporoparietal occipital area.[6] Other aberrations in the visual field are visual hallucinations. Typically the hallucinations resulting from lesions in the temporal lobes are said

to be "formed", that is of objects, whereas those arising secondary to a lesion in the occipital lobe are supposed to be "unformed" and thus consist of flashing lights or colors.

Examination of Children

Several ocular signs should be commented upon in regard to cerebral tumors in infants and children. Spreading of the sutures in an infant's and child's skull automatically supplies a decompression effect and this expansibility of the skull is one of the factors which explains in part the delayed recognition of the triad of symptoms so frequent in cases of cerebral tumor: headache, vomiting and papilledema. Probably the most important factor explaining delayed diagnosis in the young age group is the inability of the child to cooperate. While delayed diagnosis in part explains the generally unsatisfactory results in the young age group, the frequency of malignancy of the tumors in this age group is probably a more important factor. Papilledema occurs in infants and children presumably for the same reason that it occurs in adults. While it may be true, that papilledema may be delayed it is also true that papilledema in many instances is an early finding. No doubt its frequency is in part explained in the young on the frequency of cerebellar tumors and other tumors which cause obstruction in the fourth ventricle, resulting in enlargement of the ventricular system.[2] Proptosis is a sign often seen in adults, largely because of sphenoid ridge meningiomas. In children, proptosis is frequently observed in optic nerve tumors.

Pallor of the optic discs, particularly during infancy often suggests the presence of optic nerve or chiasmal involvement, when in fact the discs are quite normal. In infants when pupillary reaction to light is present, the pallor of the disc alone is always insufficient to justify diagnosis of optic atrophy. Both in children and in adults, the optic discs may retain their normal appearance when there is loss of vision in the visual fields. Because of the normalcy of the disc, the diagnosis of tumor is likely to be delayed. If it is established that there has been loss of visual fields for as long as three months, almost certainly an intracranial tumor is present.

In the ophthalmologic examination of children, it should be remembered that the normal visual acuity at one year is about 20/200. 20/30 to 20/40 vision on the Snellen chart is normal up to the age of four or five years. Children up to about the age of three years have pale discs and it is often difficult to decide whether the pallor is pathologic or normal. The problem of correct diagnosis of elevated optic discs is complicated by the many congenital variants. These include structurally full discs, tilted discs and discs containing hyaline bodies.

Multiple cranial nerve palsies, including paralysis of conjugate lateral movements, are frequently early signs of pontine tumors in which papilledema is likely to be a late sign. A most reliable combination of signs is paralysis of upward gaze with papilledema and possibly precocious puberty. This almost certainly signifies a pineal tumor.[1]

Ocular torticollis or head tilting is likely to be observed when there is paresis of a vertically acting muscle. Tilting of the head is present in order to obtain single vision or occasionally the changed position of the head may separate the images sufficiently so that they are less confusing. With an isolated paralysis of a laterally acting muscle, the head is not tilted but rather there is a turning of the face to the field of the non-functioning muscle. Such head tilts are observed in posterior fossa tumors. Internuclear palsy establishes almost beyond question that there is a lesion within the brain stem and hence points to inoperability of the tumor.[14]

Ear Signs

In recent years ENT men have been concerned with the orthopedic problems of the middle ear but it should be pointed out that in the pursiut of hearing conservation one may forget the responsibility to conserve human life itself. The otologist may be the only one who can make a diagnosis of a brain tumor early enough to spare a patient's life. Many times the only symptoms are otologic and the patient would have no reason to consult another physician. If the otologist does not constantly bear in mind the possibility that his patient with nerve deafness may have a lesion central to the cochlea, possibly in the cerebellopontine angle, referral for appropriate therapy may not be made in time to save his life.[4]

Hearing impairment, often combined with tinnitus, is the most common and early symptom of cerebellopontine angle tumors. Since the auditory symptoms are usually the first to

appear, patients with cerebellopontine angle tumors in the early stages of development are much more likely to be referred to an otologist than to a neurologist or neurosurgeon. The only widely recognized characteristic of hearing impairment, resulting from cerebellopontine angle tumors is that in except very few reported instances, it is unilateral. The audiometric configuration or impairment attributable to these tumors remains as yet substantially undescribed, yet most examiners feel that the impairment usually begins with a very minimal depression of thresholds which would commonly be regarded as insignificant, progressing to mild to moderate high-tone loss, increasing to invade the middle and low frequencies and ultimately producing a flattened curve and total impairment. After reviewing the literature, one must conclude that there is no single test in the standard battery of audiologic tests which offers infallible evidence of the existence of cerebellopontine angle tumor but that using as many measures of auditory function as can be appropriately administered usually delimits the pathologies which can conceivably be present. In addition, all too often it is assumed that the pathologic process in one ear must necessarily be etiologically the same as in the other. While this is usually true, it is untrue frequently enough to create the constant necessity for diagnostic alertness.[3]

Tinnitus is a frequent complaint of patients with angle tumors and may antedate other symptoms for months. This may resemble a high-pitched ringing or the sound of a bell or escaping steam. The presence of an annoying tinnitus may lead to early ear investigation and discovery of a hearing loss long before it might otherwise have been noted. Vertigo is not often a primary symptom in cerebellopontine tumors. Not infrequently the destructive process is so slow that the adjustment of the patient to this disturbance is complete and the patient does not complain of vertiginous attacks. In some series, as many as 50 per cent of the patients had no symptoms of vertigo. Caloric stimulation usually is absent on the involved side and X-rays of the petrous bone will show an enlarged internal auditory meatus in acoustic neuromas, however, this is a positive finding in only 45 per cent of the cases.

It is not always easy to differentiate vertigo of central nervous system origin from that of diseases of the end organ, diseases of the ganglion cells and disease of the nerve trunk. Sometimes in the early stage there are no other symptoms or signs of an intracranial disorder. The vertigo of central nervous origin frequently has a persistent character, irrespective of the stimulus of movement. The cardinal symptomatic differences between the central lesions and peripheral vestibular disease are principally the constancy of vertigo in central lesions having vertigo and nystagmus without stimulus of movement, the frequency of directional staggering associated with these attacks, and the apparent absence of anxiety and fear which often characterizes the peripheral disease. However, sometimes it is impossible to differentiate central from peripheral vertigo and the patient must be constantly re-examined.[5]

As the tumor of the cerebellopontine angle expands, paresthesias of the face usher in the second phase of syndrome. This usually precedes the facial symptoms even though the seventh nerve occupies a position close to the site of the origin of the tumor. Occasionally, facial weakness is noted earlier if the patient is extremely observant or if he used his cheek muscles to play some musical instrument. The corneal reflex is absent although there is no objective sensory loss in the trigeminal area. In any individual with progressive unexplained loss of hearing, these few cranial nerve signs are all important and should be carefully watched for.

Progressive deafness and discharge from the ear are the commonest symptoms associated with tumors of the glomus jugulare. The term glomus jugulare connotes the complex of glomera in the region of the middle ear and jugular fossa. Glomic formations in this region are to be found in various and inconstant locations. Thus several modes of extension and appearance may occur when tumors arise from them. Commonly, the first involvement is the middle ear. The tumor may arise there primarily as from the cochlear promontory, or invade from the jugular fossa below, through the thin floor of the middle ear. This early involvement of the middle ear certainly accounts for the rather common early loss of hearing. Once in the middle ear, the growth may continue laterally and destroy or push out the tympanic membrane to appear in the

external auditory canal. There the tumor usually presents as a red or bluish-red polyp in the external auditory canal or behind the tympanic membrane. Because of its extreme vascularity, hemorrhage is commonly a symptom and the tumor, which is friable, bleeds easily on manipulation, as well as spontaneously. The growth may extend upward into the petrous portion of the temporal bone, backward into the mastoid, medially toward the pharynx or inferiorly into the occipital bone or into the posterior cranial fossa. Thus a tumor arising near the jugular ganglion may be immediately within the posterior cranial fossa; that from the vagal body may project as a round hillock into the pharynx, or beneath the ear externally or both. Because of this variance in location and extension, involvement of the 3rd through the 12th cranial nerves may take place, resulting in neurological symptoms which include deafness, tinnitus, vertigo, hoarseness, dysphasia, facial weakness, diplopia and pain in the ear, head or face.[12]

Olfactory Signs

Contiguous tumors arising in the periorbital or suprasellar regions may involve the olfactory nerve by pressure along the nerve or on the cribriform plate. Loss of smell may be a symptom of intracranial tumors due to increased intracranial pressure. Sometimes one of the first symptoms of the presence of a meningioma of the anterior fossa is the loss of smell. Hence while there are no primary tumors of the olfactory nerve, involvement of this nerve is sometimes of marked significance in the neurologic examination. Loss of smell is therefore of primary diagnostic significance. While it does not indicate a tumor of the olfactory nerve, it may indicate a lesion or tumor situated in the neighborhood of the olfactory nerve or cribriform plate on the floor of the anterior fossa. Organic absence of smell is accompanied by a change in taste, since the recognition of flavors is largely an olfactory function.

In central lesions or tumors of the olfactory cortex, especially in the uncinate gyrus of either side, hallucinations of smell and dream-like states may be prominent symptoms. These odors are usually of a disagreeable nature, such as burning cabbage. This symptom is particularly valuable in localizing tumors that involve the anterior part of the temporal lobe. These olfactory hallucinations are referred to as uncinate fits. Less commonly, hallucinations of taste have also been described. It goes without saying that local nasal factors such as deflected septum, ethmoiditis and atrophic rhinitis should be checked before anosmia is diagnosed.

The word "throat" is broadly used to cover an area containing several distinctly separate structures which differ as to anatomy and function and which is innervated by the last four cranial nerves. The glossopharyngeal, vagus and spinal accessory nerves pass through the jugular foramen. The hypoglossal nerve crosses the jugular vein near its point of exit from the jugular foramen. Because of the close spatial relationship of these four nerves within the posterior fossa of the cranium at the base of the skull and the fact that the central nuclei, except for the spinal portion of the spinal accessory, lie in close association, a lesion effecting one of them is likely to involve one or more of the others. As a result, various syndromes due to involvement of various combinations of these nerves have been described.

The syndrome of the jugular foramen is characterized by loss of taste in the posterior third of the tongue (ninth cranial nerve), paralysis of the vocal cords and palate (tenth cranial nerve), and weakness of the trapezius and sternocleidomastoid muscles (eleventh cranial nerve). Many pathologic conditions including vasular lesions at the foramen, primary or metastatic tumors, fractures, and inflammatory processes are known to produce the jugular and allied syndromes. Neurinomas of the last four cranial nerves are the intracranial tumors most likely to produce these syndromes. Lesions of the 9th, 10th and 11th cranial nerves have been more frequently noted than lesions effecting all of the last four cranial nerves. The symptomatology of a combined lesion of these nerves is constant and easily recognized. The characteristic triad of symptoms is nasal regurgitation of fluids, dysphagia of solids and hoarseness representing respectively paralysis of the palate, pharynx and larynx.[13] A lesion of the glossopharyngeal nerve produces sensory loss on the soft palate and the posterior wall of the pharynx. Injury of the accessory portion of the spinal accessory nerve causes paralysis of the soft palate and larynx as well as a rapid pulse while a lesion of the spinal portion produces paralysis of the sternomastoid and trape-

zius muscles. The hypoglossal nerve may become involved by central lesions such as a tumor of the cervical cord and the medulla or peripherally as result of pressure from neoplasms in the posterior fossa. Normally the tongue within the buccal cavity lies in the midline and is protruded approximately in the center. Slight deviation of the tip to one side or the other may occur as a result of various asymmetries and should not be considered abnormal. Paresis or paralysis of one half of the tongue results in a deviation of the tip towards the affected side when the tongue is protruded, because the genioglossus muscle pushes the base forward and the unopposed action of one side pushes the tip out toward the paralyzed side. However, inside the mouth, the tip is deviated towards the healthy side because of the unopposed action of the stylohyoid muscle. Lesions of the hypoglossal nucleus or its fibers result in atrophy of the affected side. The tongue becomes wrinkled, furrowed and wasted. Supranuclear lesions result in weakness and moderate deviation of the tongue but never atrophy or fibrillations.

Nasopharyngeal Tumors

Nasopharyngeal tumors have increased in incidence and now account for about two per cent of all cancers. As with cancer in general, the hope for a good prognosis is dependent upon early recognition. Because the earliest presenting signs of a nasopharyngeal malignancy are frequently those attributable to its intracranial extension, it behooves the otolaryngologist to be familiar with the marked variability which may characterize this condition. Indeed, neurologic symptoms are the initial ones in at least 25 per cent of these tumors and the nervous system is involved at one time or another in over half of them. The reason for frequent intracranial extension of these tumors is that the usual site of origin is in close proximity to the base of the skull and particularly to the foramen lacerum and ovale. This is of even greater importance when one realizes that the sixth carnial nerve lies only 2 cm. from the fossa of Rosenmuller which is the site of origin of the majority of these neoplasms. Because of their particular location in the depths of the nasopharynx, these tumors may become quite sizable without producing any indication of their existenee until some secondary structures are involved. The cranial nerves in the middle fossa are most susceptible, particularly the fifth and sixth nerves, producing unilateral trigeminal pain and diplopia due to the lateral rectus palsy. As the tumor spreads forward, complete unilateral opthalmoplegia and blindness may develop due to involvement of the third, fourth and second nerves.

Steady unilateral facial or ear pain is the most common initial symptom of these tumors. This is trigeminal in origin and may simulate pain due to a primary tumor of the gasserian ganglion. Therefore in the presence of trigeminal pain, either with or without palsies of neighboring cranial nerves, one should suspect the possibility of such a growth and both inspect the nasopharynx directly and palpate it manually. Any suspicious area should be biopsied. However, a negative biopsy does not exclude the diagnosis. Tumors of the nasopharynx may produce abnormalities demonstrable by conventional roentgenograms of the skull. In the lateral skull films, the two important abnormalities are the presence of a soft tissue mass in the nasopharynx and destruction of the floor of the sella turica. The submental vertex or basal view of the skull is one of the most valuable projections in this disease since destruction of the bone at the base of the skull may be demonstrated in a high precentage of cases.[9]

It would seem that the role of the ophthalmologist in the diagnosis of brain tumors is as a consultant regarding the differential diagnosis of papilledema and of optic atrophy and also regarding the status of the extra-ocular muscles and the visual fields. He also acts as as ordinary practitioner referring patients to the neurological surgeon but before doing this, he might want to refer the patient to the radiologist to stregthen his basis for consulting the neurosurgeon.

The ear, nose, throat specialist must come out of his ivory petrous tower and begin to reacquaint himself with the central ramifications of the auditory nerve. He must constantly keep in mind the faet that peripheral symptomatology may very well be retrocochlear in origin and that one can never be quite certain that a given nerve deafness is purely cochlear. By virtue of his alertness and awareness of central nervous system lesions he can well make the difference between life and death of the patient. His role should be that of the

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CASE DISCUSSIONS
From The
University of Kentucky Hospitals

Florid Tuberous Sclerosis in a Patient Surviving to Age of 54 Years†

Prue Kelly, M.D.* and H. D. Rosenbaum, M.D.**

TUBEROUS sclerosis is a rare heredo-familial disease characterized by a diagnostic triad of epilepsy, mental deficiency, and adenoma sebaceum.

There are typical radiological changes in this disease which help substantiate the diagnosis in atypical cases or incomplete forms of the disease.

The incidence of tuberous sclerosis is estimated to be about 0.002% of the general population and 0.1% to 0.5 % of admissions to institutions caring for the feeble-minded and epileptics in the United States and 0.6% of similar admissions in Europe.[1] The disease often is fatal in childhood. It has been reported[2] that 30% of patients with tuberous sclerosis are dead by the fifth year of life and that 75% are dead before the 20th year of life. There are, however, cases in which all aspects of the disease are not fully developed. Although tuberous sclerosis in these incomplete forms is compatible with long life, survival of a full blown example of this disease to the late middle years is most unusual. The rarity of such long survival prompted the following case report.

Case Report

F. R., a 54 year old white male, was admitted to the University of Kentucky Medical Center on August 26, 1962 with an admitting diagnosis of epilepsy and congestive heart failure. The history, obtained from the patient's mother, revealed that grand mal seizures had occurred since early childhood. These were well controlled with medication. The patient had always been of low intelligence and did not attend school. Skin growths about the nose, chin and cheeks had been present since childhood and had continued to proliferate until the present. For the year prior to admission the patient had symptoms of congestive heart failure which became progressively worse.

There was no family history of mental deficiency, epilepsy or skin tumors. His father died at age 61 years with hypertension, heart disease, and a C.V.A. His mother is 80 years old and has heart disease and peptic ulcer disease. One sister died at age 23 years with pneumonia. One sister is age 54 years and has had surgery for carcinoma of the gastrointestinal tract. One sister and three brothers, ages not known, are reported as living and in good health.



Figure 1.

Physical examination revealed a dull, mentally defective, white male with numerous variably-sized, waxy, yellow, non-tender, movable masses distributed in a butterfly fashion about the nose and nasolabial folds. The appearance was typical of adenoma sebaceum (Figure 1). The pulse rate was 105/min., and there was peripheral edema and hepatomegaly indicative of congestive heart failure. The remainder of the examination was not remarkable.

Laboratory tests were within normal limits except

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FIGURE 2.



FIGURE 3.

for electrocardiographic evidence of sinus tachycardia and biventricular hypertrophy.

The admission chest film revealed cardiac enlargement of moderate degree. Radiographs of the skull showed a thickened cranial vault with several poorly defined nodules of increased density throughout the vault (Figure 2). In addition, a few nondescript, scattered intracranial calcifications were seen. AP films of the hands showed extensive cystic changes throughout the phalanges bilaterally (Figure 3). Similar changes were present in the feet. Some cortical sclerosis and minimal periosteal thickening was noted in the bones distal to the carpals and tarsals. Widespread nodular and streaky sclerotic lesions were also seen throughout both ilia (Figure 4). Moderate hypertrophic changes were present along the margins of both the hip joints.

The patient responded well to treatment for congestive heart failure and was discharged. Within the following six months he was admitted to a nursing home where he died. No postmortem examination was obtained.

Comments

The classical features of skin lesions, convulsions, and mental retardation of tuberous sclerosis were first described by Bourneville in 1880.[3] The disease is usually manifested early in life. In general, patients surviving to adulthood have an atypical form of the disease in which one or two of the characteristic triad are not present. When mental deficiency is slight or late in appearing, life expectancy is improved. In a review of the literature it is noted that adult cases usually have not shown the full-blown picture of tuberous sclerosis but have been instances of an atypical form in which only one or two of the characteristic diagnostic triad are present.

Tuberous sclerosis is reported[4] as being inherited as an autosomal dominant but it may be modified by an ameliorator gene. Since this patient had an unusually long survival, it would seem that his disease was modified by the presence of an ameliorator gene.

Systems other than the brain, bones, and skin are involved in tuberous sclerosis. It has been suggested that the disease consists of disseminated hamartosis.[5] The heart, kidneys, liver, and lungs may be involved with the hamartomatous lesions. Critchley and Earl[6] found renal tumors in 80% of the cases with tuberous sclerosis. Retinal tumors, or phacomas, have also been found frequently.

Roentgenographic changes are present in 65% of patients who have tuberous sclerosis.[2] Marcus in 1924, as cited by Dalsgaard-Nielsen,[7] first noted the intracranial calcifications of tuberous sclerosis. In 1935 Gottlieb and Lavine[8] observed osseous lesions in the hands and feet. These findings have been verified by a number of authors, notably Holt and Dickerson,[9] who reported that lesions also may occur in other parts of the skeleton.

The roentgenological changes in the skull seen in the case presented are typical of the disease. The sclerotic densities are due to hamartomatous tissue in the brain substance as well as reactive sclerosis in the overlying cranial vault. Pneumoencephalograms have shown filling defects in the ventricular system due to tuberous sclerosis lesions in this location.

(Continued on Page 360)



FIGURE 4.



the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

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SPECIAL ARTICLES

Special Communication

P.L. 89-239: Education, Research, Training and Demonstrations in the Fields of Heart Disease, Cancer, Stroke and Related Diseases

ROBERT C. LONG, M.D.*

Louisville, Ky.

THE YEAR 1965 witnessed the enactment into law by the 89th Congress many bills concerning the health care of this Nation. The two bills of greatest importance were P.L. 89-97, the Medicare Law, and P.L. 89-239. The importance of these two pieces of medical legislation can scarcely be overemphasized, for their impact may bring about profound changes not only in medical practice but also in our very system of medical care. Every physician should be well informed about the Medicare Law for it has occupied a prominent place in our political scene since 1957, and it is not the purpose of this communication to discuss it further. On the other hand, the provisions of P.L. 89-239 are scarcely known to the physician, the public or to the politician, for that matter. It is the purpose of this article, therefore, to examine the origin of this law, its more important provisions and to speculate upon the impact it may have on medical practice in the years that lie ahead. This article will also recount in some detail the role that the American Medical Association played in amending the bill shortly before it was enacted into law.

Let us then briefly review some of the legislative history of P.L. 89-239. On January 7, 1965, shortly after the 89th. Congress convened, President Johnson delivered his health message to the Congress. In the middle of this speech, the President turned to a subject which was destined to be of special interest to the health professions. Mr. Johnson called for an "all out attack" on heart disease, cancer and stroke and other major diseases. On January 19, Congressman Oren Harris of Arkansas, Chairman of the House Interstate and Foreign Commerce Committee, introduced H.R. 3140, the Heart Disease, Cancer, and Stroke Amendments of 1965. On that same day Senator Lister Hill of Alabama, Chairman of the Senate Labor and Public Welfare Committee introduced a companion bill, S. 596. At this time, Medicine had no indication of the speed with which these bills would be brought up for consideration.

Both H.R. 3140 and S. 596 and that portion of the President's Health Message were based upon the report of the President's Commission on Heart Disease, Cancer and Stroke, commonly known as the DeBakey Commission, named after the chairman, Doctor Michael E. DeBakey. The Commission published Volume I, which contained its recommendations and findings, in December 1964. It was not until February 1965, that the Commission published Volume II containing the reports of the various subcommittees and study groups whose findings were supposedly the basis for the first volume's conclusions. In effect, the Commission's findings were published a full two months before the data upon which they were supposedly based became available. It should also be noted that the Administration's bills were introduced a month prior to the publishing of Volume II of the Commission's report. For reasons which are mainly unknown, there seemed to be an uncommon haste to act upon a major bill which could radically change the patterns of medical practice.

In early February, with only a few days notice, a Subcommittee on Health of the Senate Labor and Public Welfare Committee held two days of hearings on S. 596. The then-secretary of HEW, Mr. Celebrezze, and his staff, opened these hearings in the Senate presenting the Administration's testimony. The lack of understanding as to the established provisions of H.R. 3140 and S. 596 soon became apparent. During the question and answer period, the Secretary was asked for cost estimates for the program beyond its first year of operation but was unable to provide such information since HEW had not anticipated that this legislation would be so swiftly introduced. In the secretary's words: ". . . I am surprised we came in with any kind of legislation because, as I say, this report was just finalized in December of last year, and we are just in February now." In spite of Secretary Celebrezze's surprise with which the legislation was introduced and in spite of the concern expressed by some of the senators over the unknown costs of the program, the Senate easily passed the bill by a voice vote.

As you may recall, the American Medical Asso-

Doctor Long is a member of the Board of Trustees of the American Medical Association.

ciation sponsored an Orientation Conference on Heart Disease, Cancer and Stroke in Washington, D.C. at the Statler Hilton on Sunday, July 18, 1965. At that time representatives of the various state medical societies were brought together to gain an understanding of this bill and to assist the AMA in obtaining some delay in Congressional action on the measure. Shortly after this Orientation Conference, the House Interstate and Foreign Commerce Committee held public hearings on H.R. 3140 with Doctor Appel and Doctor Hussey appearing on behalf of the Association. It was pointed out to the Committee that the bills under consideration were extremely vague, not only in their language, but in the manner in which the provisions of the bill were to be implemented. The AMA asked that the House Committee delay action until definitive and supportable information could be gathered as to the best possible method of constructively accelerating research and care in heart disease, cancer and stroke.

When the House hearings opened, by the best information available, all the members of the Interstate and Foreign Commerce Committee either favored these bills or at least were unaware of any reason why they should not speedily pass them on to enactment. No one had really raised any objections to the bill. No one, that is, until the American Medical Association appeared before the Committee and challenged the Commission's premises and conclusions with facts and figures. The AMA raised these objections in the face of possibly being charged with being "against motherhood and for sin." In the question and answer period which followed, Congressman James Harvey, Representative from Michigan commented:

> "As I sat here and listened to the searching questions put to you I can't help but think that certainly the easy way for the Medical Association and yourself would have been simply to have agreed with the President's Commission and say yes, anytime you spend money on these diseases it is bound to be a good thing. Certainly, we in this country, and I speak for myself here as a Congressman, don't want our medical profession to be composed of yes men. I don't think we have obtained the finest medical profession in the world because you have been yes men but because of the reverse, they have always had the courage to come in and express their views and to challenge the views as they have seen them. I can't help but think as we sit here that the American people are going to benefit because you and Doctor Hussey and the others have had the courage to come in here and challenge some of the recommendations of the President's Commission. I assure you that as a member of this Committee that we will benefit from your testimony and because you have helped to focus attention on the issues of whether a gap actually does exist and whether this is the correct way to close that gap and we will benefit by that. As a member I would like to thank you."

At this point it would seem appropriate to state the basic objectives of the bill as originally written and then to summarize the objections raised by the AMA in its testimony before Congress. The ostensible aim of the bill was to provide for a network of regional medical complexes across the country to combat heart disease, cancer, stroke and other maior diseases. Each complex would have a medical school and a teaching hospital at its core. Linked to them would be categorical research institutes and diagnostic and treatment stations in outlying community hospitals.

A summary of the AMA testimony follows:

1. "From the outset, we want to make unmistakably and unequivocally clear our agreement with the President's Commission on Heart Disease, Cancer and Stroke in the ostensible objective of reducing or eliminating the incidence of, and deaths, from these diseases."

2. The Legislation is vague. "The recommendations of the Commission and the pending legislation raise many questions that still remain unanswered. Whatever their differences after the Senate action, the measures before you are vague and openended. There are no definitions really of a program; no limitations on authority, no guideline for pursuing a course of action, no meaningful limitations of expenditures except for lump sum allotments. I fear the effect of this legislation would be to seriously hamper our well-proven existing patterns of research, education and patient care.

Nowhere in the Commission's report or in these bills are the criteria spelled out for establishing the vast array of new complexes. Also lacking are clues as to how the complex is expected to enhance the physicians ability, how he might actively participate in a complex, what criteria he could follow for increasing his store of knowledge, and how precisely these complexes will provide him with new and proven techniques with which to treat his patients."

3. "There is not available sufficient manpower to meet the needs of the proposed regional medical complexes."

4. "The creation of regional medical center complexes will discourage physicians from locating in suburban or rural areas."

5. "There is no serious lag in the dissemination of new discoveries to the time of their application."

The DeBakey Commission's Subcommittee on Research stated: "This Subcommittee and its consultants are unaware of any significant body of fundamental information which is stagnantly awaiting clinical application by competent practitioners. Indeed, it considers that the art of clinical investigation consists, in large measure, of a considered, deliberate judgement of the utility and applicability of such fundamental information and careful avoidence of the meaningless, feckless, and indeed harmful activities which are the consequences of illconsidered attempts to apply the inapplicable."

The Subcommittee on Research also stated that there has been no major breakthru accomplished by research related to cancer, heart disease, and stroke which currently awaits application. There must be a time in which new diagnostic and therapeutic

developments are evaluated by physicians in relation to their own patients.

6. "Adoption of a regional medical complex law will not, in our opinion, improve communication of new diagnostic and therapeutic discoveries to the practicing physician.

The present system of consultation and referral makes available to the physician for his patients a knowledge of the specialist and facilities of the medical centers. Further, as we have previously stated, continuing education programs provide physicians with opportunities for keeping abreast of new discoveries."

7. "Without the proposed legislation the present system of distribution of medical care, medical education and research *is* attacking heart disease, cancer and stroke.

"Research in heart disease, cancer and stroke is today supported with vigor by Federal and other government agencies and by private voluntary efforts. Finally, we must recognize that thru the practice of consultation and referral patients today receive specialized services for care of these and other major diseases.

"While this Nation's program for health care is praiseworthy we, along with this Committee, recognize that there is still much to be done, but we would caution with one caveat.

"It is a scientific fact of life that increased money alone, whether its source be public or private, will not bring about a breakthru in heart disease, cancer, stroke or any other disease. Claims that cancer and heart disease are capable of being prevented or cured at this time are misleading and tend to substitute emotional judgement for factual understanding. The report of the Subcommittee on Research of the President's Commission says in part: 'It is for this reason (the complexity of human biological research) that guarantees or promises that, next year or the following, we shall understand cancer or heart disease or arthritis or schizophrenia are both extravagant and irresponsible.

One day we almost certainly shall possess such understanding. But whereas cancer and heart disease have probably been with man since first he appeared on this planet, biomedical science is virtually a newborn babe. About 90% of all the biomedical scientists in history are alive and working today, and most of them began working after 1945. The studies in which they are engaged are immensely complex and difficult. Utterly desirable as attainment of their goals may be, their research, which can be facilitated and even somewhat accelerated, simply cannot successfully be hurried and none can say when the labor will be completed.'

8. "We urge the Committee to put this legislation aside until it can be studied and evaluated in all respects. HR 3140 and S. 596 and the Commission's report are ostensibly a plan to support and accelerate medical research and training. In effect, however, the pattern of medical practice and patient care would be changed. The Nation must not take on a course of action before it knows what the probable effects will be to the everyday medical care of its people."

This is an incomplete but, it is hoped, a pertinent summary of AMA testimony given to the Congress on July 27, 1965. It should be emphasized at this point that many other organizations also testified, principally the American Heart Association, the American Cancer Society and several constituent State Medical Societies. In some respects their testimony was similar to that of the AMA, while in other respects it differed rather substantially.

In spite of the objections raised by the AMA and others, it became apparent in late August that a bill, differing little from the original version, would be favorably reported out of the House Committee on Interstate and Foreign Commerce. And so it appeared that a law would be enacted that would contain almost all of the provisions so vigorously objected to by so many responsible and knowledgeable organizations. It was at this time that the AMA Board of Trustees decided to go over the head of the House Committee directly to President Johnson, and it so instructed his Advisory Committee, which had been meeting regularly with the Secretary of HEW in regard to regulations concerning the Medicare Law. The Board felt that continuing liaison with Secretary Gardner would be markedly aggravated by the enactment of another law so strongly opposed by physicians.

And so one evening the Advisory Committee and Secretary Gardner and his staff met with the President to discuss the impending legislation on heart disease, cancer and stroke. Our representatives requested, as they had in their testimony, that further action on this highly controversial bill be postponed pending further study. The President refused to consider this request. However, after further discussion President Johnson directed Health Secretary Gardner to work with the AMA Committee "to make the bill less objectionable."

That evening and the next day the Advisory Committee and its staff, working with HEW officials, wrote twenty amendments into the House bill. These amendments were promptly supported by the administration and are part of the present law. Most of these amendments were substantive and significantly altered the intent and scope of the original bill. Space does not permit the inclusion of these amendments in this communication. They are available for those who may wish them. However, there is one very important change that should be emphasized, and that is that the intent of the original bill was to set up regional *treatment* centers throughout the country. The emphasis, although never admitted by the administration, was on patient care rather than on research, training and education. The present law, as a result of the amendments referred to above, emphasizes education, research and training, and patient care may be carried out only as demonstrations related to them. As a matter of fact, one of the amendments eliminated the words *Complexes* and *Treatment* from the title of the law.

Whether these amendments will accomplish their objectives depend upon many factors, not the least of which are the regulations by which this law will be implemented. At the time of this writing these regu-

lations have not been published. One thing, however, seems certain, and that is that there will be a continuing and increasing encroachment by Government on every aspect of Medicine: education, research and patient care. We, the profession, being aware of this must not abrogate our responsibility to the people in our determination to provide the highest quality of medical care to all. We should strongly support those programs which would help to achieve this noble goal; and we must vigorously oppose any program which would result in the deterioration of quality medical care.

Specifically, the following changes were made in HR 3140:

1—No national network of regional complexes is now established.
2—The word "coordinated" wherever it appeared has now been replaced by the word "cooperative."
3—The bill now applies to heart, cancer, stroke and "related diseases" not to "other major diseases."
4—Practicing physicians are given a significant role on local advisory committees and on the statutory Advisory Council to the Secretary.
5—The "demonstrations" provided in the original bill must now be related to research and training.
6—The emphasis in the amended bill is on the operation of pilot projects whose effectiveness will be subject to review before new projects are approved.
7—The statutory Advisory Council is now a body with power to veto as well as advise.
8—New construction is eliminated from the bill. The amended bill provides construction funds for alteration, repair, remodeling and renovation of existing buildings.
9—The term "diagnostic and treatment stations" is deleted entirely from the bill and replaced by the word "hospital."
10—Only patients who have been referred by a practicing physician can receive the care provided, which now must be incident to research, training, and related demonstrations.
11—Appropriations were reduced from $650,000,000 over a four-year period to $340,000,000 for three years.

This is Your Opportunity

to attend the

1966 Annual Meeting of the AMA

June 26-30

McCormick Place, Chicago

(See registration forms pages 280 & 281)



For Better Use of Our Health Resources

THE DEMANDS for hospital care have so increased during the past twenty years that, despite an enormous expansion of facilities under the Hill-Burton Act and other agencies, we are increasingly pressed to find available accomodations for those patients who are urgently in need of treatment. We are now aware that there must be careful and systematic community planning if the sick are to be properly handled. This will include the construction, expansion and improvement of general and specialized hospitals, geriatric centers, nursing homes and institutions for chronic and incurable diseases.

The American Medical Association, American Hospital Association, Blue Cross, United States Public Health Service, and the U.S. Department of Health, Education and Welfare have been acutely aware for the past ten years of the necessity of such community planning and have sought, independently and in cooperation, to establish councils, especially in the larger urban centers. There has been apathy or rather indifferent response to such effort the country over. This has been due largely to the magnitude of such undertaking, to the lack of precedent and to difficulty in commanding the attention of community leaders to the urgent necessity. Kentucky has been slow to encourage such activity and has accomplished little with the exception of an area in the Northern counties which has in fact been a part of the Greater Cincinnati Hospital Planning Council. We have thereby perhaps done unwise building in some areas and failed in obtaining federal matching funds in instances where hospital construction was urgently needed.

Now that this need is better understood a new impetus for health facilities planning is being felt and regional organizations are in process of being formed. This is being encouraged not only by those engaged in the health professions but by other civic leaders as well. The Kentucky Chamber of Commerce and local chambers have begun to take an energetic role in the enterprise.

The Governor's executive order creating a twenty-man advisory council for health facilities states that such planning efforts "seek to achieve optimal utilization of limited resources so as to maximize the effectiveness, efficiency, and economy of medical care." Mr. Laurel W. True, Director of the Health Facilities Program of the Kentucky Department of Health at Frankfort, has outlined the purposes and the plan of organization. He envisions twenty geographic areas in the state, each of which is to be served by regional planning bodies for the purpose of securing accurate information regarding the health needs and advising the Health Facilities Program on the necessity for construction and modernization of hospitals and other health facilities in that area.

The construction of such a body is set forth in this language: "The governing body of the regional planning agency should have a membership drawn from recognized community leadership and broadly representative of all areas within the region. Health professionals including administrators and physicians should be members of the governing body; however, the majority of members should be lay persons without professional or financial interest in health facilities." The Director emphasizes that planning bodies must be so constituted and approved by the State Health Facilities Program before their cooperation and authority for that area are recognized. Only one such body in a given area will be used as a source of information and advice in statewide health facilities planning and in allocation of Federal matching funds.

In instances where no such voluntary regional health facilities planning agency has been

recognized the Commissioner of Health may be authorized to appoint an ad hoc sub-committee of the Advisory Council to serve temporarily within that region.

The need for such planning becomes more apparent every year in both the rural and urban communities of the State. Our emphasis in the past has been upon building general hospitals primarily for the care of acutely ill persons. Without special provisions for the chronically ill we have been compelled to care for them in accomodations which were designed primarily for emergency and seriously ill patients. We thereby have a constant shortage of acute bed space. Provision for convalescent care has largely been neglected. It is anticipated that with the advent of the new program July 1st of this year our problems will be further compounded and it will take several years, even with the most diligent and intelligent planning, to readjust.

The most advantageous location of acute hospitals in rural areas has always been a problem but with the rapid increase of urban population and the longer distances within our cities the proper location of acute facilities more accessible to the peripheral areas is an increasing concern. Duplication of costly equipment in hospitals located short distances apart is constantly cited as an important factor in the rapidly rising cost of medical care. However, with the constant enlargement of our metropolitan hospitals it is doubtful if this is as important a factor as advertised.

During the past twenty years facilities for educating physicians have been greatly expanded and this has increased our annual graduating classes by more than a thousand. It is anticipated that within the next five to ten years it will be increased by another thousand. Yet the demands of government, Public Health, industry, teaching and research have engaged so many of the best trained that, in the private practice of medicine, we are actually worse off than we were twenty years ago when there were 105 physicians to 100,000 population. Today there are 97 and every indication that this ratio will worsen rather than improve. Physicians are now generally overworked and with a rapidly increasing population and more intensive care of older people required there is little prospect for more leisurely years ahead. We will have to try by every reasonable means to increase our efficiency and effectiveness.

Mr. Samuel S. Long, Executive Secretary of the Hospital Planning Association of Toledo, Ohio, defines the purpose of areawide or community planning in part "to promote the highest quality and quantity of patient care within the resources of the community to provide" — expressed almost exactly as in the Governor's executive order noted above. He feels that we spend so much time and energy repairing the mistakes and inadequacies of yesterday that we neglect to plan ahead for the necessities of tomorrow — He has something there!

SAM A. OVERSTREET, M.D.

This Is a Good Year To Go

THE CITY is Chicago and the date is June 26th-30th, 1966 for the 115th Annual Convention of the American Medical Association. There has not been a year in the memory of any of us when American medicine has been confronted with the necessity of making more important decisions and charting a course of action for our future. The President, Doctor James Z. Appel, has given generously of his time and energy to present before all physicians who would hear, a fair appraisal of what is ahead for medicine, and the considered opinion of our governing bodies regarding our plans. Other officers and trustees have been almost equally as active.

The Convention in Chicago being scheduled for the last four days of this half-year is designed to bring before us the very latest thoughts concerning our future course. The business of the House of Delegates will in all probability command a greater amount of attention and interest this year than will the traditionally fine scientific sessions.

Every physician who finds it possible to attend should be there. He should have an open mind, alert attention and a ready pen and notebook in order to bring back to his fellows the sense and the message of this meeting. Chicago will be crowded, but there will be room for you.

SAM A. OVERSTREET, M.D.

ORGANIZATION SECTION

Color TV, Top Guest Lecturers Slated for Annual Meeting

Color television clinics and a variety of individual presentations by sixteen top-ranked guest speakers will highlight the 1966 KMA Annual Meeting September 20-22 in Louisville, according to Everett H. Baker, M.D., Louisville, KMA president and chairman of its Council on Scientific Assembly.

The program, to be held again this year at the Convention Center on Sixth and Walnut Streets, is being planned by the Scientific Program Committee with Roderick Macdonald, Jr., M.D., Louisville, as its chairman.

Four-and-a-half hours of color television will be presented at the general scientific sessions, and two hours at specialty meetings, under the sponsorship of Smith Kline and French Laboratories. Speakers from a wide range of medical specialty fields will be the guests of sixteen affiliated specialty groups, and will also present papers at the general sessions.

A popular feature of last year's meeting, the arrangement of the program so that general and specialty meetings will not conflict, will be in effect again this fall. A record number of scientific and technical exhibits is expected for the 1966 Annual Meeting.

Headquarters for the meeting will again be the Kentucky Hotel, where the House of Delegates will convene twice. Reference committees will also meet at the hotel.

Other features of the meeting will be the annual University of Louisville Medical Alumni reunion, for which plans are now being made; individual reunions for ten classes; and the third Orientation program for new members.

AMA to Hold 1966 Convention In Chicago June 26-30

A large number of Kentucky physicians are expected to attend the 115th Annual Convention of the American Medical Association June 26-30 in Chicago, according to KMA president Everett H. Baker, M.D., Louisville.

The scientific program will be held at McCormick Place and the House of Delegates will convene at the Palmer House, which will serve as convention headquarters. Six topics will be presented in the general scientific sessions. They are: population expansion, emphysema, burns, mysterious fevers, community hospital coronary care units, and headache.

Color television and medical motion pictures will be among the features of the Convention again this year. Both will be presented daily at the general sessions, and several of the scientific sections will participate in this year's color television program.

Twenty-three specialty sections will present scientific programs, many of which will be joint meetings of two or more sections and, in some instances, a specialty society. Special sessions on nursing, maxillofacial surgery and nuclear medicine will be held. Other highlights will include approximately 350 scientific exhibits and hundreds of industrial exhibits.

Doctor Baker has urged that Kentucky physicians plan to attend this, the most important medical meeting of the year. He advised that hotel reservations be made as early as possible. A form for this purpose appears on page 280 of this issue of *The Journal.* Further information on the program and activities of the meeting will be carried in later issues.

Legislative Chairman Summarizes Ky. General Assembly Actions

A total of 1,133 bills and resolutions, of which 10 per cent were related to health matters, were introduced into both houses of the 1966 Kentucky General Assembly, which adjourned Friday evening, March 18, according to J. Campbell Cantrill, M.D., chairman for state affairs of the KMA Council on Legislative activities.

Doctor Cantrill said all of these bills were carefully screened by the KMA staff and those with medical implications were brought to the attention of the KMA Council on Legislative Activities. The Council had to meet three times during the session, once jointly with the Executive Committee of the KMA Board of Trustees. In addition, one telephone conference on the legislative program was held with the Executive Committee.

One of the critical votes came early in the session when the Senate voted to postpone action indefinitely on S.B. 11 which would have permitted chiropractors to be recognized under the Workmen's Compensation Act and to be paid for services rendered.

There were two other bills, Doctor Cantrill said, which were sponsored and strongly backed by KMA. The first, H.B. 197, would have provided two years of college "prior to the commencement of his professional education and training" in the healing arts professions. This bill passed the House without a dissenting vote, but failed to come to a vote in the Senate.

However, S. B. 295, which prohibits advertising by members of the healing arts passed in the final days of the session. All major bills, the council

(Continued on Page 338)

chairman said, that KMA felt were not in the public interest failed to pass.

Deep appreciation was expressed by Doctor Cantrill for the splendid support that the KMA Legislative Key Man System and other members of the profession provided in this very important session. He and other KMA leaders expressed satisfaction generally with the developments in this year's legislature.

It was pointed out that this material was being written immediately after the session, just as *The Journal* was going to press. A summary of the more important bills relating to public health will be prepared and distributed to all county societies and KMA Legislative Key Men. Doctor Cantrill urged each society to study this material carefully.

In closing, the council chairman paid high tribute to Mr. Gilbert Armstrong, KMA's chief lobbyist, for his services in the recent session. He felt that Mr. Armstrong performed exceedingly well in view of this being his first experience. He also praised Mr. Robert G. Cox, who assisted Mr. Armstrong, for his good work in giving valuable assistance in the closing days of the session.

Eleven Leading Guest Speakers To Address KAGP May 11-13

Eleven guest authorities, including a representative of the U.S. Division of Medical Care Administration, will address Kentucky general practitioners at the annual meeting of the Kentucky Academy of General Practice May 11-13 in Louisville, according to Carroll L. Witten, M.D., Louisville, KAGP president.

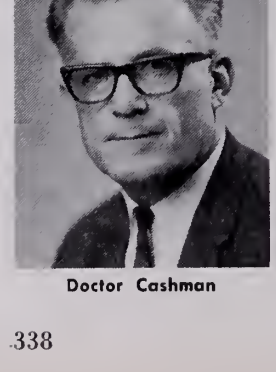
"July 1st—Now What?" will be the topic of John W. Cashman, M.D., main speaker at the Thursday luncheon session. Doctor Cashman is chief of the Division of Medical Care Administration of the United States Public Health Service.

Four former Louisvillians will be among the speakers at the Fifteenth Annual Scientific Session, Clarence E. Quaife, M.D., Louisville, program chairman, said. The three-day meeting will be held at the Kentucky Hotel.

The four former faculty members at the University of Louisville School of Medicine are Arthur H. Keen M.D., Philadelphia; Joseph A. Little, M.D., Nashville; Hugh B. Lynn, M.D., Rochester, Minn.; and Richard P. Schmidt, M.D., Gainesville, Fla.

Doctor Little, associate professor of pediatrics and chief of the pediatric diagnostic and ambulatory care unit at Vanderbilt, will present papers entitled "The By-Products of a Pediatric Cardiology Service" and "Anaphylactoid Purpura—Revisited."

Other speakers on the program will be Thomas L. Marchioro, M.D., Denver; Richard G. Martin, M.D., Houston; Richard E. Palmer, M.D., Alexandria, Va.; Franklin D. Schwartz, M.D., Chicago; John P. Utz, M.D., Richmond; and William H. Weidman, M.D., Rochester, Minn.



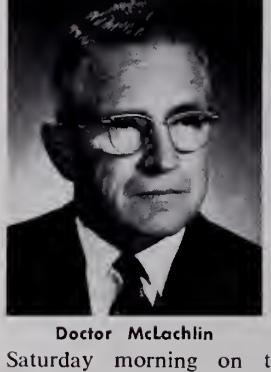
Doctor Cashman



Doctor Little

Ky. Surgical Society Program To Feature Dr. McLachlin

A top-ranked Canadian surgeon and medical educator will be the key speaker at the annual meeting of the Kentucky Surgical Society at French Lick, Ind., May 13 and 14, Rudolf J. Noer, M.D., Louisville, Society president, has announced.



Doctor McLachlin

Angus D. McLachlin, M.D., professor and head of the department of surgery at the University of Western Ontario, London, Ont., will address the Society on Saturday morning on the "Sequelae of Venous Thrombosis and Their Management", Blaine Lewis, M.D., Louisville, secretary, said in discussing the program.

Other topics will be covered in presentations by members of the Society. They will include: "Cancer of the Large Bowel", "Intestinal Obstruction Due to Meckel's Diverticulum", "Surgical Problems in Patients with Neglected Low-Grade Neoplasms", "Diagnosis and Treatment of Occult Cancer of Breast", and "Acute Urinary Tract Trauma and its Treatment".

Doctor McLachlin, who has held his present position since 1945, is a member and has been an officer in many of the surgical societies in Canada and the United States. He is a fellow of the Royal College of Surgeons of both Canada and England, and a fellow of the American College of Surgeons.

He received his undergraduate medical training at the University of Western Ontario, receiving an M.D. degree there in 1932, and a Master of Science in 1933. His Ph.D. was received at the University of Oxford, England in 1936, and an M.S. in surgery from the University of Toronto in 1942.

The two-day meeting will include a business meeting and election of officers, Doctor Noer said.

Sixth District Plans Meeting

Members of the KMA Sixth Trustee District and their wives will meet for the second time this year at Bowling Green on Tuesday evening, June 14, according to Rex E. Hayes, M.D., Glasgow, trustee. Further information will be published in the May *Journal.*

Dr. Kinsman Retires at U. of L.; To Resume Active Practice

J. Murray Kinsman, M.D., vice-president of the University of Louisville and former dean of its medical school, has retired and will resume private practice in Louisville.



Doctor Kinsman

He was dean of the School of Medicine from 1949 until 1963, when he became a vice president of the University. He had been a member of the medical faculty for 38 years. He will be associated in practice with William C. Buschemeyer, M.D., with whom he practiced before becoming dean of the medical school.

Doctor Kinsman, a native of Nova Scotia, was awarded his medical degree by McGill University in Montreal in 1922, and completed his residency in medicine at Louisville General Hospital. He is a past president of the Jefferson County Medical Society and the Innominate Society.

Winner of Scientific Exhibit To Receive $200 Award

The Executive Committee of the KMA Board of Trustees has unanimously approved a recommendation of the Scientific Exhibits Committee to present a $200.00 cash award sponsored by Mead Johnson Laboratories to the individual presenting the best scientific exhibit at the KMA Annual Meeting.

This is the first year that a cash prize will be awarded to a scientific exhibitor. In addition, a certificate and a KMA wall plaque will also be given for the winning exhibit.

A special committee is appointed by the Scientific Exhibits Committee to judge all scientific exhibits presented at the Annual Meeting. The judges normally recognize at least two other exhibits in addition to the first place winner.

In past years approximately twenty-five scientific exhibits have been presented at each KMA Annual Meeting. Exhibitor application forms can be found in the March through June issues of the KMA *Journal*. (See Page 350 of this issue.) July 1, 1966 is the deadline for receiving applications for this year's Annual Meeting.

Ky. Orthopedic Society to Meet

The Kentucky Orthopedic Society will hold its annual meeting at the Springs Motel in Lexington on Saturday, April 23, Society president David Stevens, M.D., Lexington, has announced. Robert D. Ray, M.D., chairman of the department of orthopedics at the University of Illinois School of Medicine will be the main speaker.

The program will begin at noon at the University of Kentucky Medical Center in cooperation with the department of continuing education. The evening meeting will be held jointly with the Cincinnati Orthopedic Society. All KMA members are invited to attend the meeting. A golf tournament will be held on Sunday.

Twelfth KMA Trustee District To Meet in Somerset May 25

As The Journal went to press it was learned that the KMA Twelfth Trustee District will hold its annual meeting at the Quality Court Motel in Somerset on Wednesday, May 25.

According to Robert F. Long, M.D., Somerset, District trustee, the meeting will start with a scientific program at 4:30 p.m. A social hour will begin at 6:00 p.m. and dinner at 7:00, followed by an address by KMA president Everett H. Baker, M.D., Louisville, and a discussion of the KEMPAC program.

Doctor Long said that personal invitations will be issued for the meeting to physicians and their wives in the Twelfth District. Assisting Doctor Long in preparations for the session are Steven B. Kelley, M.D., Somerset, president of the Pulaski County Medical Society, and William Wyatt, M.D., Somerset, society secretary.

May 1-7 Proclaimed by Governor As State Immunization Week

Immunization Week in Kentucky will be observed this year May 1-7, according to Ralph D. Lynn, M.D., Elkton, chairman of the KMA Public Health Committee.

The purpose of the program is to achieve, as nearly as possible, complete immunization in the state against polio, diphtheria, pertussis, tetanus, smallpox, typhoid fever, and measles.

In proclaiming Immunization Week, Governor Edward T. Breathitt has joined the Kentucky Medical Association and other state organizations in urging all Kentuckians to check the immunization records of their families.

Children need immunization most, the KMA committee points out, but adults should keep track of their own records, particularly in the case of the major communicable diseases. All KMA members are urged by Doctor Lynn to check the immunization records of families under their care, with special emphasis on children. The success of the program depends on physicians, he said.

Diabetes Assn. to Meet May 12

The Kentucky Diabetes Association will hold its annual interim meeting at the University of Kentucky on Thursday, May 12, beginning with a Board of Directors Meeting at 10:30 a.m. The general program, on the production and action of insulin, will last from 1:00 to 5:00 p.m. All interested physicians are invited to attend the meeting in room MN 442 in the Medical Center.

First aid for a button popper



Second aid for a button popper



By providing combined anorexigenic-tranquilizing action, BAMADEX SEQUELS Capsules help your nonshrinking patients to establish new patterns of eating less. The amphetamine component suppresses the appetite, while the meprobamate helps allay nervousness and tension. And for most patients, the *sustained* release of the active ingredients provides convenient one-capsule-a-day dosage.

Side Effects commonly associated with either component are possible but, to the extent these are dose-related, they should normally be mild and infrequent, since the total dosage of each component on the usual one-capsule-daily regimen is quite low. Also, the sedating effect of meprobamate and the stimulating effect of d-amphetamine sulfate tend, to some extent, to cancel each other out. Adverse effects not peculiar to either component have not been reported. Side effects associated with d-amphetamine sulfate include: insomnia, excitability, increased motor activity, confusion, anxiety, aggressiveness, increased libido, hallucinations, rebound fatigue, depression, dry mouth, anorexia, nausea, vomiting, diarrhea and increased cardiovascular reactivity. Effects associated with meprobamate include: skin rash, nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema, fever and transient leukopenia; also, very rarely, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, stomatitis, proctitis and anaphylaxis. Other serious effects have occurred after concomitant administration of meprobamate and other drugs. Massive overdosage may produce grave effects.

Precautions: BAMADEX SEQUELS should be given only under close supervision to patients hypersensitive to sympathomimetic drugs, with cardiovascular or coronary disease or who are severely hypertensive; to emotionally unstable persons and to epileptics. Patients should be cautioned not to drink alcoholic beverages while on the drug, and not to drive vehicles if they become drowsy. In all patients kept on the drug for long periods, the drug should be withdrawn gradually to avoid possible serious reactions.

Contraindications: Hyperexcitability, agitated prepsychotic states and a history of previous reactions to meprobamate.

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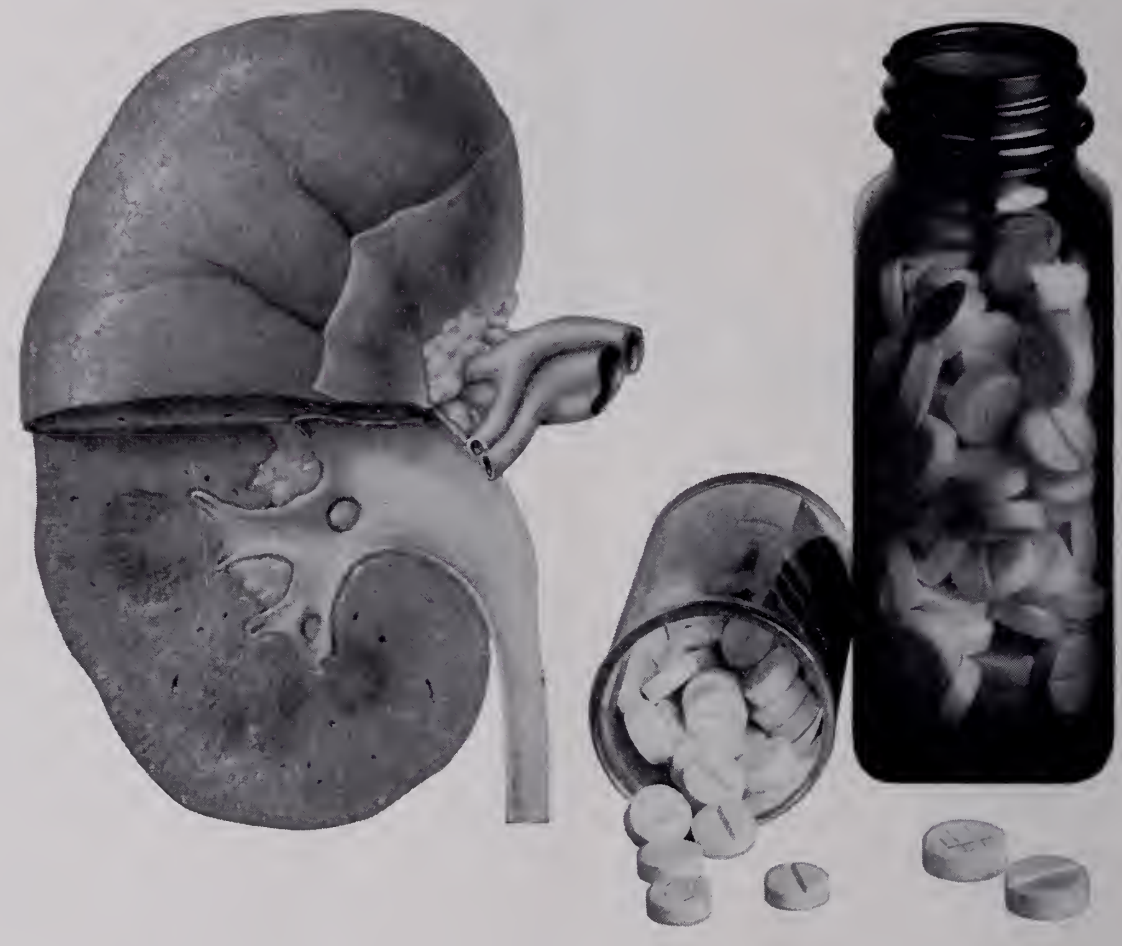
d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.) Sustained Release Capsules

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at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD **MERCK SHARP & DOHME** Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

to help relieve pain in common anorectal disorders

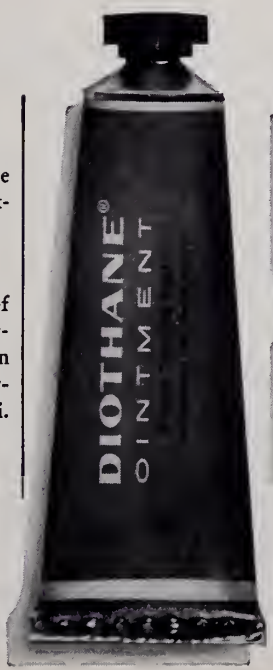
"non-caine" Diothane®

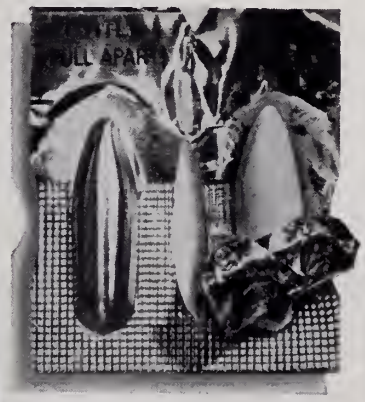
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form... both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

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Three Kentucky Physicians Return From HOPE Ship Mission

Three Kentucky physicians returned March 15 from a two-month voluntary tour of duty aboard the SS HOPE hospital ship in Nicaragua. One served on the HOPE two years ago.

The three are: John C. Weeter, M.D., Louisville plastic surgeon, who completed his second tour; Samuel L. Cooke, M.D., Louisville otolaryngologist; and Harold D. Rosenbaum, M.D., chairman of the department of radiology at the University of Kentucky.

They were among 30 volunteer U.S. physicians, who with nurses and technologists, treated patients and gave classroom instruction to their Nicaraguan counterparts. The ship will remain there until November.

Ky. Thoracic Society Symposium Set April 21 in Louisville

Several of the country's leading authorities on respiratory disease have accepted invitations to speak at the Kentucky Thoracic Society's annual symposium April 21 in Louisville, according to Herbert T. Ransdell, Jr., M.D., Louisville, president.

The day-long meeting will be held at Rankin Amphitheater, Louisville General Hospital, beginning at 9:00 a.m., Grover B. Sanders, M.D., Louisville, program chairman, has announced. The topic of the morning session will be "Bacterial and Viral Respiratory Infections," and the afternoon session will deal with "Environmental Factors in Respiratory Disease," Doctor Sanders said.

The guest faculty will include John C. Sinclair, M.D., New York Babies' Hospital; C. Rollins Hanlon, M.D., St. Louis University School of Medicine; James McCarroll, M.D., Cornell University; and Ernest L. Wynder, M.D., Sloan-Kettering Institute for Cancer Research, New York City.

Doctor Ransdell has urged that all physicians plan to attend "what promises to be a highly interesting and richly rewarding session," See advertisement, page 345, for further information.

Year-Round Diabetes Screening Approved for Kentuckians

A year-round statewide blood sugar diabetes screening program sponsored by the Kentucky State Department of Health has been approved by the KMA Diabetes Committee, according to Irving F. Kanner, M.D., Lexington, chairman.

The program is made possible by the recent purchase of an auto analyzer, an automated system for continuous chemical examination.

A representative from the county health department will meet with each county medical society to decide first if there is a need for such a program, and if so, to determine what group or groups of people are to be screened.

After approval, the State Health Department will furnish most of the necessary supplies for the program, including blood containers, record forms, and educational material.

The Kentucky Medical Association started the first Diabetes Detection and Education program for the country in 1951. In the 15 years of existence, a significant service has been rendered to the public, Doctor Kanner said. More than 2,300 previous unknown diabetics have been found, and if they are willing to follow usual procedure will live normal lives.

Ky. Medical Assistants to Meet May 14-15 in Louisville

"Time Capsule '66" will be the theme of the Fourth Annual Convention of the Kentucky State Association of Medical Assistants on Saturday and Sunday, May 14 and 15 in Louisville, according to Mrs. Wanda Taylor, Louisville, president.



Doctor Baker

Medicare, mentally disturbed patients, Americans in Vietnam, and reconstructive hand surgery will be among the topics presented by speakers during the session at Stouffer's Louisville Inn.

Everett H. Baker, M.D., president of the Kentucky Medical Association, will address the group at the Sunday luncheon session. Other speakers named will be George F. Brockman, M.D., Greenville, and Harold E. Kleinert, M.D., Louisville.

A representative of Metropolitan Life Insurance Company, carrier for Kentucky for the Medicare program, will deliver an address on the administration of the program. Smith Kline and French Laboratories will sponsor a speaker who will discuss mental disturbances.

The meeting will begin at 10:00 a.m. Saturday and end at 2:30 p.m. Sunday. A banquet will be held at 7:00 p.m. Saturday.

KMA Represented at Ethics Meeting

KMA's new Judicial Council was represented at the AMA's First National Conference on Medical Ethics by N. Lewis Bosworth, M.D., Lexington, chairman, and another member of the council, Henry B. Asman, M.D., Louisville, KMA secretary.

The two-day meeting was held in Chicago March 5 and 6. Leading speakers were James Z. Appel, M.D., Lancaster, Pa., AMA President, and Walter H. Judd, M.D., Washington, D.C., a member of AMA's Judicial Council.

Dr. Denham Named to U. K. Board

Harry C. Denham, M.D., Maysville surgeon, was recently reappointed by Governor Edward T. Breathitt as a member of the University of Kentucky Board of Trustees. Doctor Denham's term will expire December 31, 1969. He is a partner in the Denham Clinic at Maysville with his brother, Mitchel B. Denham, M.D.

Attention Physicians!

YOU ARE INVITED TO ATTEND

Scientific Session Of The Kentucky Thoracic Society

APRIL 21, 1966

THE RANKIN AMPHITHEATER — LOUISVILLE GENERAL HOSPITAL
HERBERT T. RANSDELL, JR., M.D., PRESIDING

Morning Session

THEME: *"Bacterial and Viral Respiratory Infections"*
MODERATOR: Grover B. Sanders, M.D.

9:00 - 9:10 *GREETINGS!*
Donn L. Smith, M.D., Dean
University of Louisville School of Medicine

9:10 - 9:55 *INFECTIONS IN ADULTS*
Walter Daly, M.D.
Indiana University School of Medicine
Indianapolis, Indiana

9:55 - 10:40 *RESPIRATORY DISEASES IN BABIES*
John C. Sinclair, M.D.
New York Babies' Hospital
New York City

10:40 - 11:25 *ROLE OF TRACHEOSTOMY IN RESPIRATORY INSUFFICIENCY*
C. Rollins Hanlon, M.D., Chairman
Department of Surgery
Saint Louis University
Saint Louis, Missouri

11:40 - 12:00 *PANEL DISCUSSION*—Speakers listed above

Afternoon Session

THEME: *"Environmental Factors in Respiratory Diseases"*
MODERATOR: Hugh Scott Fulmer, M.D.

2:00 - 2:45 *AIR POLLUTION*
James McCarroll, M.D.
Department of Public Health
Cornell University
New York City

2:45 - 3:30 *CURRENT CONCEPTS ON THE ETIOLOGY OF RESPIRATORY TRACT CANCER*
Ernest L. Wynder, M.D., Chief
Div. Environmental Cancerogenesis
Sloan-Kettering Institute for Cancer Research
New York City

3:30 - 4:15 *ENVIRONMENTAL FACTS—AIR POLLUTION AND SMOKING*
Hugh Scott Fulmer, M.D., Associate Professor
Department of Community Medicine
University of Kentucky Medical Center
Lexington, Kentucky

4:30 - 5:00 *PANEL DISCUSSION*—Speakers listed above

KMA Announces 13 New Members Enrolled as of March 15

Thirteen Kentucky physicians have been added to the membership lists of KMA during the period from February 15 through March 15, according to the records of the membership department.

Included are: Keith E. Ellis, M.D., Benton; Carl Henry, M.D., Paducah; Van R. Jenkins, M.D., Carlisle; and Don C. McFadden, M.D., Mt. Sterling.

Completing the list are the following, all from Lexington: James W. Bard, M.D.; Joe D. Bernard, M.D.; Herbert Braunstein, M.D.; Edward P. Crawford, M.D.; Gordon K. Danielson, M.D.; Ward O. Griffen, Jr., M.D.; Robert D. Milledge, M.D.; Lloyd F. Redick, M.D.; and David E. Weinstein, M.D.

Annual Samuel D. Gross Lecture To be April 18 in Louisville

David M. Hume, M.D., chairman of the department of surgery at the Medical College of Virginia, will be the Phi Delta Epsilon fraternity's Samuel D. Gross Lecturer at 11:00 a.m., April 18 at Rankin Amphitheater, Louisville General Hospital.



Doctor Hume

The lecture, the 25th of the series named in honor of the late Samuel D. Gross, professor of surgery at the Louisville Medical Institute from 1840-1855, is co-sponsored by Phi chapter of Phi Delta Epsilon and the department of surgery at the University of Louisville.

Doctor Hume will speak on organ transplantation. A former faculty member at Harvard University School of Medicine, he is recognized as the first to achieve a successful kidney transplantation. He has held his current post at the Medical College of Virginia since 1956.

New Deanship Goes to Dr. Cheng

Samuel H. Cheng, M.D., was named the first assistant dean for clinical affairs at the University of Louisville School of Medicine in action taken March 17 by the U. of L. Board of Trustees.

Doctor Cheng will coordinate the work of interns, residents and fellows in hospitals affiliated with the school, and will be primarily responsible for recruiting interns and residents. He has served as associate professor of medicine and chief of gastroenterology until this appointment.

Dr. Deuschle Named to VN Team

Kurt W. Deuschle, M.D., chairman of the department of community medicine at the University of Kentucky was named by President Johnson recently to serve on a 15-man task force to combat hunger, ignorance, and disease in Vietnam.

Doctor Deuschle, who was responsible for the one-of-its-kind "Senior Clerkship" program in community medicine at the University, formerly served with the U.S. Public Health Service and with the medical school faculties of Cornell University and the State University of New York Upstate Medical Center.

Cardiovascular Program Planned By U.K. Radiology Dept.

A symposium on Cardiovascular Disease will be presented by the department of radiology at the University of Kentucky Medical Center May 2-6, Harold D. Rosenbaum, M.D., professor and chairman of the department, has announced.

Doctor Rosenbaum said that an outstanding guest faculty will be composed of the following: Herbert L. Abrams, M.D., Stanford University; John A. Campbell, M.D., University of Indiana; Benjamin Felson, M.D., University of Cincinnati; Mordecai Halpern, M.D., University of Southern California; and D. J. Hanson, M.D., Roger Williams Hospital, Providence, R. I.

Others are: G. B. C. Harris, M.D., Children's Hospital Medical Center, Boston; R. Brian Holmes, M.D., University of Toronto; Joseph Jorgens, M.D., VA Hospital, Minneapolis; John Keith, M.D., Hospital for Sick Children, Toronto; Eugene C. Klatte, M.D., Vanderbilt; J. Stauffer Lehman, M.D., Hahnemann; Richard G. Lester, M.D., Duke; Thomas R. Marshall, M.D., University of Louisville; and R. Van Praagh, M.D., Hektoen Institute for Medical Research, Chicago.

Dr. Gaither Honored by Hospital

J. Gant Gaither, M.D., Hopkinsville, a past president of the Kentucky Medical Association, was honored January 31 at ceremonies dedicating to him a new addition to Jennie Stuart Memorial Hospital at Hopkinsville. Doctor Gaither has served for many years as a member of the hospital board of trustees.

A retired physician and surgeon, Doctor Gaither was graduated in 1907 from the University of the South Medical Department, Sewanee, Tenn., and practiced in Mississippi before returning to his native Hopkinsville in 1910. A plaque bearing his name and a portrait of Doctor Gaither will hang in the new wing of the hospital.

Ky. Student Awarded Fellowship

Elizabeth Ann Wright of Kernville, Cal., a junior at the University of Kentucky College of Medicine, is one of 35 U.S. medical students to receive foreign fellowships for supervised medical experience in under-developed areas of the world, the Association of American Medical Colleges announced February 25. The fellowships are made possible by a grant from Smith Kline & French Laboratories of Philadelphia. Miss Wright will work at Nehora Health Center, Hevel Lachish, Israel for at least 10 weeks.

BRING IT DOWN AND KEEP IT DOWN



Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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Care-by-Parent Pediatric Unit Open at U. K. Medical Center

A new, one-of-a-kind pediatric ward for minimally-ill children is now open at the University of Kentucky Medical Center. The ward is designed and operated so that a parent may remain with a child during the hospital stay and assume complete care for the patient.

No nurses are assigned, and the reduction in personnel is reflected in reduction of hospital charges. Rooms are equipped like motel rooms, with private bath, and a parent utility room with laundry and kitchen equipment assists parents in caring for children.

Therapeutic and diagnostic procedures, consultations and many tests may be scheduled in advance, thus reducing the length of stay. The ward is under the direction of a full time pediatric staff member. Admission is by referral.

Ob-Gyn Collection Planned For U. of L. Medical Library

The Louisville Obstetrical and Gynecological Society has initiated a plan to establish and develop a collection devoted to obstetrics and gynecology and related subject matter at Kornhauser Memorial Library at the University of Louisville School of Medicine.

The Library and Museum Committee of the Society is anxious to collect books, journals, memorabilia, instruments, works of art, manuscripts, class notes, class cards, diplomas, physicians' diaries, old professional advertising or catalogs, or other material related to the specialty.

The committee invites any member or friend of the medical profession to contribute to the collection, either through gifts of the actual items, or contributions to the fund. Gifts or inquiries should be addressed to the committee, Louisville Obstetrical and Gynecological Society, Kornhauser Memorial Medical Library (U. of L.) 101 West Chestnut St., Louisville, Ky., 40202.

Dr. Gray to Speak in Africa

Laman A. Gray, M.D., Louisville, clinical professor of obstetrics and gynecology at the University of Louisville, will address the East London Congress of Obstetrics and Gynecology beginning March 31 at East London, South Africa.

Doctor Gray will return to Louisville April 29 after serving as a visiting professor of obstetrics and gynecology at medical schools in South Africa, at the University of Cairo, Egypt, and the University of Athens, Greece.

Zimmerman Resigns C. of C. Post

James C. Zimmerman, Louisville, executive vice-president of the Kentucky Chamber of Commerce since 1961, resigned February 27 to accept the office of executive vice-president of the Owensboro National Bank. Mr. Zimmerman joined the Kentucky Chamber staff in 1955 as director of industrial development.

U. of K. Researchers Get Grant

A grant of $10,400 was recently awarded to Charles B. Wilson, M.D., and Horace Norrell, M.D., both of the department of surgery at the University of Kentucky, for research on the cause of hydrocephalus in infants. The Easter Seal Research Foundation gave the grant as part of a total three-year commitment of $28,013.

Pertinent Paragraphs

The Academy of Psychosomatic Medicine has announced the Annual Award contest for the best paper (not over 4000 words) on a clinical or research subject in psychosomatic medicine. Deadline for submitting papers is August 1, 1966. For more information, write to Benjamin Schneider, M.D., chairman, 123 E. Market St., Danville, Pa.

The American Geriatrics Society has announced the renewal of three $1800 grants to encourage resident physicians to devote more time to the study of the medical problems of the aging. The grants, made possible by Lederle Laboratories, will cover the period between July 1966 to June 1967.

The Annual Otolaryngologic Assembly of 1966 will be held October 1-7 in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago. Interested physicians should direct inquiries to: Department of Otolaryngology, P.O. Box 6998, Chicago, Ill., 60680.

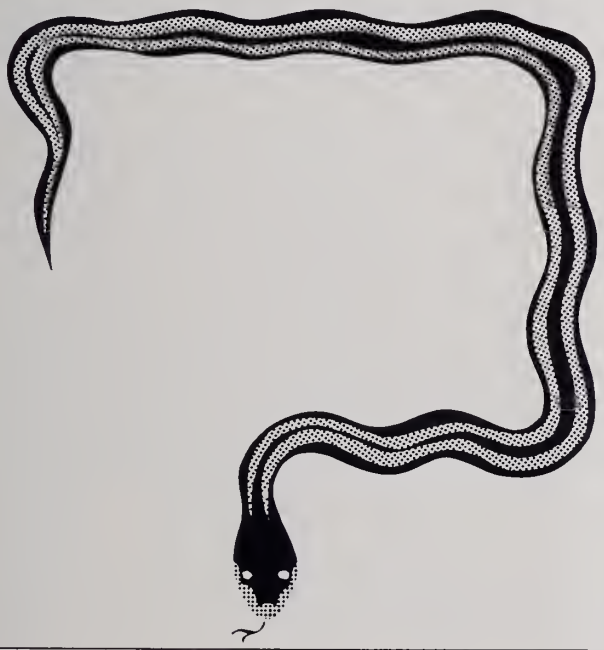
A few years ago nomenclature purists insisted that drugs be named to indicate their chemical structure . . . We refer to corticosteroids, thiazide diuretics, sympathetic amines, anticholinergics, phenothiazines and anticoagulants but we resort to a contrived word to identify the particular drug we want. We know drugs more by their actions than by their precise chemical structures, which, after all, is the essential information. By analogy, if we know how to operate a motor vehicle competently, it isn't really very important whether or not we know the dimension of the cylinders, its compression ratio or the mechanism of the automatic transmission.—Theodore G. Klumpp, M.D., in *GP*, (32:197-198), November, 1965.

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(mepenzolate bromide)

helps restore normal motility and tone

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide) —25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL —containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Convention Center — **Louisville, Kentucky** — **September 20, 21, 22**

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Committee on Scientific Exhibits

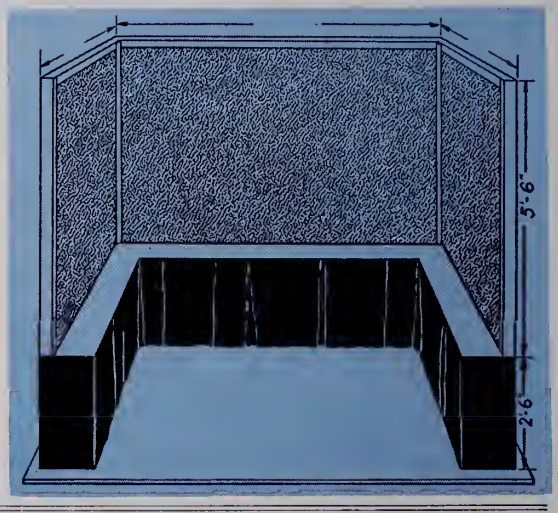
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1966

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....

   .....

   Institution (if desired): .....

   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings .... X-rays....

   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:

   Amount of wall space needed? .....

   Back wall .....Side walls (All side walls are 4') .....

   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Mead Johnson Aesculapius Award of $200.00 and identifying plaque will be presented by the KMA for the best exhibit in 1966.

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*

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Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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NEWS ITEMS

Joe G. Conley, M.D., a 1964 graduate of the University of Louisville School of Medicine, is now serving on active duty with the U.S. Naval Reserve in Louisville. Doctor Conley, who holds the rank of Lieutenant, is stationed at the Armed Forces Examining Station. He completed his internship last July at Louisville General Hospital.

Ronald L. Levine, M.D., Louisville, has opened an office in that city for the practice of obstetrics and gynecology. Doctor Levine was graduated from the University of Louisville School of Medicine in 1959 and interned at Louisville General Hospital. Following three years of general practice, he completed his residency at the same hospital.

Richard F. Keeler, M.D., is the new public health officer for Letcher County, with offices at Whitesburg, according to a recent announcement. Doctor Keeler, a 1964 graduate of the University of Virginia College of Medicine, interned at Norfolk General Hospital.

F. A. Martin, M.D., a urologist, has started practice at Paris. Doctor Martin, who graduated in 1956 from the Manila Central University, interned at Manila Sanitarium and Hospital in the Philippines, and at St. Joseph Hospital in Lexington. Following completion of his residency in urology, he served a one-year preceptorship in urology, and maintained a private practice in Manila for two years. Doctor Martin came to Paris from Pikeville.

Edmund V. Currie, M.D., has started general practice at Harlan, where he is associated with the Daniel Boone Clinic. A native of Canada, Doctor Currie received his medical degree from the University of Toronto in 1949. Following ten years of practice in Montreal, he was a surgical resident at St. Joseph Infirmary in Louisville and is continuing his surgical training in Harlan.

Joseph Book, M.D., one of the founders of the Daniel Boone Clinic at Middlesboro, has resigned to serve for three years under the Committee of Manpower Opportunities in Israel.

Robert B. Cloar, M.D., a general practitioner at Middlesboro, has given up his practice and moved to Dallas, Tex., where he will take residency training, according to recent press reports.

B. J. Jackson, M.D., a general practitioner, has become associated with **Lewis E. Wash, M.D.,** at Lawrenceburg, according to a recent announcement. Doctor Jackson, who was graduated in 1962 from the University of Louisville School of Medicine, interned at St. Joseph Infirmary in Louisville. He was discharged in January from the U.S. Navy with the rank of lieutenant.

J. S. Bean, M.D., former secretary of the Hardin County Medical Society, was the subject of a feature story in the Elizabethtown *News* honoring him on his birthday, February 13. Doctor Bean, who graduated in 1904 from the Hospital College of Medicine in Louisville, began his practice in Ohio County, and has practiced in Hardin County for fifty years.

Robert A. Stewart, M.D., Ashland, has been awarded a special post-doctoral fellowship grant by the U.S. Public Health Service and will study at Yale University. Doctor Stewart, a pathologist and a graduate of Wayne State University School of Medicine, will work with Averill A. Liebow, M.D., at Yale. He has practiced at Ashland for seven years.

KMA Council and Committee Reports

Council on Medical Education and Hospitals

George A. Sehlinger, M.D., Louisville, Chairman

KMA Headquarters Office **March 3, 1966**

The council on Medical Education and Hospitals met at the KMA Headquarters office to discuss PL 89-239, Heart, Cancer, Stroke Amendments of 1965. A detailed report was given by Donn L. Smith, M.D., dean of the University of Louisville School of Medicine. Dean Smith told the council that several medical school deans have held meetings to study methods of carrying out regulations in the law. The council recommended that some time be given at the 1966 Interim Meeting at Cumberland Falls for Doctor Smith to bring other Kentucky physicians up-to-date on this program.

The council reviewed the critique of the Medical Education Conference at Park Mammoth and agreed that it was a very valuable meeting. It was the concensus of the council that a meeting of this type be held every other year.

James B. Holloway, M.D., chairman of the KMA Hospital Committee, reported on his committee's plans for a state-wide hospital planning commission. After much discussion on this subject, it was moved that Doctor Holloway present to the Executive Committee a proposal for development of this program under the auspices of KMA.

KMA Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman, National Affairs; J. Campbell Cantrill, M.D., Georgetown, Chairman, State Affairs

Your KMA Council on Legislative Activities held three very important meetings during the 1966 Session of the Kentucky General Assembly for the primary purpose of considering legislative proposals introduced into the Legislature.

These meetings were held on January 12 in Louisville and on February 9 and March 2 in Frankfort.

In addition, the Council considered a number of issues at the national level. Several recommendations were made to the KMA Board of Trustees.

The Council on Legislative Activities wishes to express appreciation to all the members who participated in efforts to pass good legislation or resist legislation that was not deemed to be in the public interest.

(Continued on Page 354)



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Diabetes Committee

Irving F. Kanner, M.D., Lexington, Chairman

KMA Headquarters Office **March 2, 1966**

Members of the Diabetes Committee, at its recent meeting at KMA Headquarters office, reviewed the 1965 Diabetes Program which just concluded. The chairman pointed out that a total of 66,501 free tests were reported, 252 new diabetics reported, and 985 positives were found during the drive. The chairman also said the number of tests reported was down from last year, possibly due to the State Health Department not reporting its results separately. Considerable discussion was held in outlining plans for the 1966 drive this fall, which will be held November 13-19.

The committee heard a report from Mr. Omar Greeman, acting director of the Chronic Diseases Division of the State Health Department, who announced that the department would soon be able to make available a capillary blood sugar test for year-round diabetes detection.

School Health Committee

O. B. Murphy, M.D., Lexington, Chairman

KMA Headquarters Office **February 23, 1966**

Members of the KMA School Health Committee met at the Headquarters Office and primarily discussed previous efforts made to get a better physical education program in the state's school system. Members of the committee agreed that additional attempts be made to state educational authorities for inclusion of such a program in the regular school curriculum.

The committee reviewed school health activities previously initiated and members agreed to continue promoting them with special emphasis on the program designed to develop a good liaison between the KMA School Health Committee and local county society school health chairmen. Members of the committee briefly discussed the school health exhibit, "Health Appraisal of the School Child": which will be displayed at the KEA Annual Convention.

The committee chairman also gave a report on the Seventh National Conference on the Medical Aspects of Sports, which was held in Philadelphia last November during the AMA Clinical Meeting.

Public Health Committee

Ralph Lynn, M.D., Elkton, Chairman

KMA Headquarters Office **February 24, 1966**

Discussion of a venereal disease education program in the state of Kentucky highlighted the recent meeting of the KMA Public Health Committee. Thomas Wallace, M.D., a member of the committee, gave a detailed report on the recent AMA Meeting he attended regarding the same subject. Doctor Wallace discussed an educational program now in progress throughout Kentucky and pointed out there is a shortage in the educational material being used due to the school systems' interest.

The committee approved a promotional program for Immunization Week which the members set for May 1-7. A brief discussion also was held on Community Health Week. Members felt this program will probably grow in future years and that local county medical societies should develop local health projects during the Community Health Week.

KMA Technical Advisory Committee On Indigent Medical Care

C. C. Waldrop, M.D., Williamstown, Chairman

Frankfort, Ky. **March 9, 1966**

The KMA Technical Advisory Committee on Indigent Medical Care met in Frankfort on March 9, 1966 with William H. McBeath, M.D., director of the Department of Medical Assistance, and his staff.

G. L. Simpson, M.D., Greenville, chairman of the Governor's Advisory Council on Medical Assistance, reviewed the entire Medical Assistance Program in Kentucky since its inception.

Doctor McBeath and his staff summarized Title XIX of PL 89-97 (Medicare), as well as Sections A and B of Title XVIII.

The Committee voted to meet again for the purpose of framing recommendations to be presented to the KMA Board of Trustees for its consideration when it meets at Cumberland Falls on April 13.

Vascular Injuries

(Continued from Page 321)

astomosed to aid wound healing and prevent distal atrophy.

4. A plea is made to consider restoration of circulation rather than to sacrifice the extremity.

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Ky. Physicians in the Armed Forces

Douglas R. Alvey, M.D., Franklin, general practitioner, has reported to Brook Army Hospital at Fort Sam Houston, Tex., after which he will go to Fort Benning, Ga. He is one of a number of Kentucky physicians drafted in the recent special call. A 1961 graduate of the University of Louisville School of Medicine, he completed his internship at Indianapolis General Hospital in 1962.

COUNTY SOCIETY REPORTS

McCracken

The regular meeting of the McCracken County Medical Society was held at Boswell's Restaurant on February 23, Walter Johnson, M.D., Paducah, president, presiding.

George Keiser, M.D., St. Louis, presented the scientific program on his experience with cardiac pacemakers. His speech was illustrated with slides, and in conclusion, a motion picture of the surgical procedure for implanting the pacemaker was shown.

Following a brief intermission, Doctor Johnson called the business meeting to order. The secretary read a letter from the American Medical Association regarding the increase of annual dues to $70.

Other correspondence from KMA was read, thanking the Society for hosting the First District meeting in January, and expressing the appreciation of the president, Everett H. Baker, M.D.

The Society president authorized a letter of appreciation to Lt. Governor Harry Lee Waterfield for his negative vote to break the 17-17 tie on Kentucky Senate Bill II, which would authorize chiropractors to practice under the Workman's Compensation Act. A second letter was authorized to Senator Tomm Garrett, who also voted against the bill.

Doctor Johnson then urged the members to write to state senators and representatives urging their support of House Bill 197, which requires an applicant for licensure in the healing arts to have completed two years of college education.

A correction was made in times announced for future meetings. The social hour will begin at 5:30, dinner at 6:30, and the scientific program at 7:00.

The meeting adjourned at 8:20 p.m.

Following are those county medical society officers reported by press time. Additional lists of officers will be published in later issues.

Allen

President, Earl P. Oliver, M.D.; vice-president, John M. Hall, M.D.; secretary-treasurer, Owen L. Davis, M.D.; delegate, F. J. Halcomb, Jr., M.D.; alternate, Doctor Davis. All are from Scottsville.

Campbell-Kenton

President, Dexter Meyer, M.D., Covington; president-elect, Donald Janney, M.D., Covington; vice-president, Robert O'Conner, M.D., Fort Thomas; secretary-treasurer, C. C. Hugan, Jr., M.D., Covington; delegates, C. J. Brueggemann, M.D., Covington, Donald K. Dudderar, M.D., Newport, W. V. Pierce, M.D., Covington; Thomas L. Heavern, M.D., Newport; Paul H. Klingenberg, M.D., South Fort Mitchell; and Robert T. Longshore, M.D., Covington.

Clay

President, J. L. Becknell, M.D., Manchester; vice-president, Ira F. Wheeler, M.D., Oneida; secretary-treasurer, W. E. Becknell, M.D., Manchester; delegate, Doctor W. E. Becknell; alternate, Doctor Wheeler.

Crittenden

President, James O. Nall, M.D.; vice-president and secretary, R. M. Brandon, M.D.; delegate, Doctor Brandon; alternate, Doctor Nall. Both are from Marion.

Floyd

President, James A. Holbrook, M.D.; vice-president, James D. Adams, M.D.; secretary-treasurer, Russell L. Hall, M.D.; delegate, Doctor Adams; alternate, Lowell Martin, M.D., Martin, Ky. All but Doctor Martin are from Prestonsburg.

Franklin

President, John P. Stewart, M.D.; vice-president, William A. Johnson, M.D.; secretary-treasurer, Doyle D. Hagg, M.D.; delegates, Sanford L. Weiler, M.D., (two years), Harry Cowherd, M.D. (one year); alternates, Thomas H. Baker, M.D. (two years), and Joseph Liebman, M.D. (one year). All are from Frankfort.

Fulton

President, Robert W. Bushart, M.D.; vice-president, Glynn F. Bushart, M.D.; secretary-treasurer, J. A. Poe, M.D.; delegate, Doctor Robert Bushart; alternate, R. T. Peterson, M.D. All are from Fulton.

Grayson

President, P. A. O'Neill, M.D., Leitchfield; vice-president and president-elect, R. A. Cave, M.D., Leitchfield; secretary-treasurer, Ralph G. Thomas, M.D., Leitchfield; delegate, C. L. Bland, M.D., Leitchfield; alternate, A. L. Embry, M.D., Millwood.

Green

President, George Cheatham, M.D.; secretary-treasurer, Kenneth J. S. DeSimone, M.D.; delegate, Robert P. Simmons, M.D.; alternate, Robert L. Shuffett, M.D. All are from Greensburg.

Greenup

President, Charles B. Johnson, M.D., Russell; vice-president, Virgil Skaggs, M.D., Russell; secretary-treasurer, C. I. Haeberle, M.D., Russell; delegate, John O. Jones, M.D., Flatwoods; alternate, Doctor Johnson.

Harlan

President, Charles J. Corea, M.D., Lynch; vice-president, Howard L. Elliott, M.D.; secretary-treas-

(Continued on Page 358)

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urer, James K. Hurlocker, M.D.; delegates, Henry Evans, M.D. and Doane Fischer, M.D.; alternate delegates, Gilbert Hamilton, M.D., and Walter H. Stepchuck, M.D., Evarts. All but Doctors Corea and Stepchuck are from Harlan.

Hopkins

President, William Gardner, M.D.; vice-president, Arthur Hall, M.D.; secretary-treasurer, Kenneth P. Haywood, M.D.; delegates, Loman Trover, M.D. and Frederick Scott, M.D.; alternates, Frederick Ferguson, M.D. and James Freeman, M.D., Dawson Springs. All but Doctor Freeman are from Madisonville.

Meade

Secretary, George E. Clark, M.D., Brandenburg; delegate, Doctor Clark.

Mercer

President, Bacon R. Moore, III, M.D.; vice-president, John S. Baughman, III, M.D.; secretary-treasurer, C. B. VanArsdall, Jr., M.D.; delegate, Doctor Moore; alternate, E. H. John, M.D. All are from Harrodsburg.

Montgomery

President, D. P. Edmundson, M.D.; vice-president, E. L. Jones, M.D.; president-elect, Roy M. Kash, M.D.; secretary-treasurer, R. J. Salisbury, M.D.; delegate, Doctor Salisbury; alternate delegate, D. C. McFadden, M.D. All are from Mount Sterling.

Morgan

President, George R. Bellamy, M.D.; vice-president and president-elect, Morris L. Peyton, M.D.; secretary, Alec Spencer, M.D.; delegate, Doctor Bellamy; alternate, Doctor Peyton. All are from West Liberty.

Nelson

President, Emmett W. Wood, M.D., Bardstown; vice-president, Tyree G. Forsee, M.D., Bardstown; secretary-treasurer, William R. Yates, M.D., Bloomfield; delegate, James M. Millen, M.D., Bardstown; alternate, Kenneth L.Stinnette, M.D., Bardstown.

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Pendleton

President, W. M. Townsend, M.D., Falmouth; secretary-treasurer, Robert L. McKenney, M.D., Falmouth; delegate to KMA, Doctor McKenney; alternate delegate, Doctor Townsend.

Pulaski

President, Steven B. Kelley, M.D.; vice-president, Elmer R. Smith, M.D.; secretary-treasurer, William Wyatt, M.D.; delegates, Barton L. Ramsey, M.D. and Doctor Wyatt; alternates, Gerald A. Weigel, M.D. and Doctor Kelley. All are from Somerset.

Shelby-Oldham-Henry

President, Wyatt Norvell, M.D., New Castle; president-elect, W. P. McKee, M.D., Shelbyville; secretary-treasurer, A. D. Doak, M.D., Shelbyville.

Wayne

President, Robert B. Breeding, M.D.; vice-president, Claude L. McHargue, M.D.; secretary-treasurer, W. Robert Kelsay, Jr., M.D.; delegate, Doctor Breeding; alternate, John W. Simmons, M.D. All are from Monticello.

Webster

President, E. W. Atherton, M.D., Clay; vice-president, W. W. Wainer, M.D., Providence; secretary-treasurer, J. A. Logan, III, M.D., Sebree; delegate, Paul M. Taylor, M.D., Providence.

Woodford

President, Lewis Wash, M.D., Lawrenceburg; vice-president and president-elect, Ben F. Roach, M.D., Midway; secretary-treasurer, Olson Parrott, M.D., Versailles; delegate, Doctor Wash; alternate, Doctor Roach.

Signs of a Brain Tumor

(Continued from Page 327)

careful physician who will keep in mind not only the turbinates, tonsils and the peripheral ear but the entire central nervous system.[4]

This has been an attempt to reacquaint the ear, eye, nose, and throat specialists with some of the signs and symptoms encountered in their field which suggest the presence of a brain tumor.

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In Memoriam

OSCAR WILLIAM FRICKMAN, M.D.

Newport, Ky.

1899 - 1966

Oscar W. Frickman, M.D., 66, of Newport, died suddenly at his home in Fort Thomas on February 5. Semi-retired from his practice of industrial medicine, Doctor Frickman had served as medical director of Interlake Steel Corporation and of Acme-Newport Steel Company. He was graduated in 1923 from the Medical Department of the University of Cincinnati.

CARL ALBERT MARQUARDT, M.D.

Augusta, Ky.

1905 - 1966

Carl A. Marquardt, M.D., a general practioner and Augusta's only physician, died suddenly February 11, nine days after his 61st birthday. Doctor Marquardt, who was active in civic, religious and fraternal affairs, had practiced in Bracken County since 1935. He was a 1931 graduate of the Loyola University School of Medicine, Chicago.

JOHN ANDREW SNOWDEN, M.D.

(Formerly) Winchester, Ky.

1882 - 1966

John A. Snowden, M.D., 83, former Winchester general practitioner, died February 17, at Clewston, Fla., following a short illness. Doctor Snowden, a former mayor of Winchester, was a 1908 graduate of the Kentucky School of Medicine in Louisville. He had been active in medical, civic, and religious affairs in his community.

CECIL CLAUD MERRITT, M.D.

Tollesboro, Ky.

1884 - 1966

C. C. Merritt, M.D., 81, Tollesboro, who retired in 1962 after more than 50 years of general practice, died March 9. Doctor Merritt had practiced in Lewis, Fleming, and Mason counties since his graduation from the Medical Department of the University of Louisville in 1910. He was an emeritus member of the Kentucky Medical Association.

JOHN B. FLOYD, SR., M.D.

Lexington, Ky.

1888 - 1966

John B. Floyd, Sr., M.D., 78, Lexington, former director of the Kentucky Department of Health's division of tuberculosis, died March 10 at a Lexington hospital after a long illness. Doctor Floyd, who was retired, practiced for many years in Richmond. He was graduated in 1915 from the Medical Department of the University of Louisville. He was instrumental in the use of mobile x-ray units in Kentucky in fighting tuberculosis. Doctor Floyd was an emeritus member of KMA.

Florid Tuberous Sclerosis

(Continued from Page 329)

The cyst-like changes in the phalanges and the distinctive type of periosteal new bone formation along the shafts of the metatarsals and metacarpals are characteristic of this disease. The cystic areas of the phalanges result from non-specific fibrous replacement of bone. The periosteal thickening is typically wavy, irregular and may be localized.

Summary

A case of tuberous sclerosis, with the characteristic diagnostic triad of epilepsy, mental deficiency and sebaceum adenoma, is presented in an adult surviving to the age of 54 years. Characteristic roentgenological changes in the bones were present. The case was unusual in that patients with the characteristic full-blown picture of tuberous sclerosis rarely survive until this age.

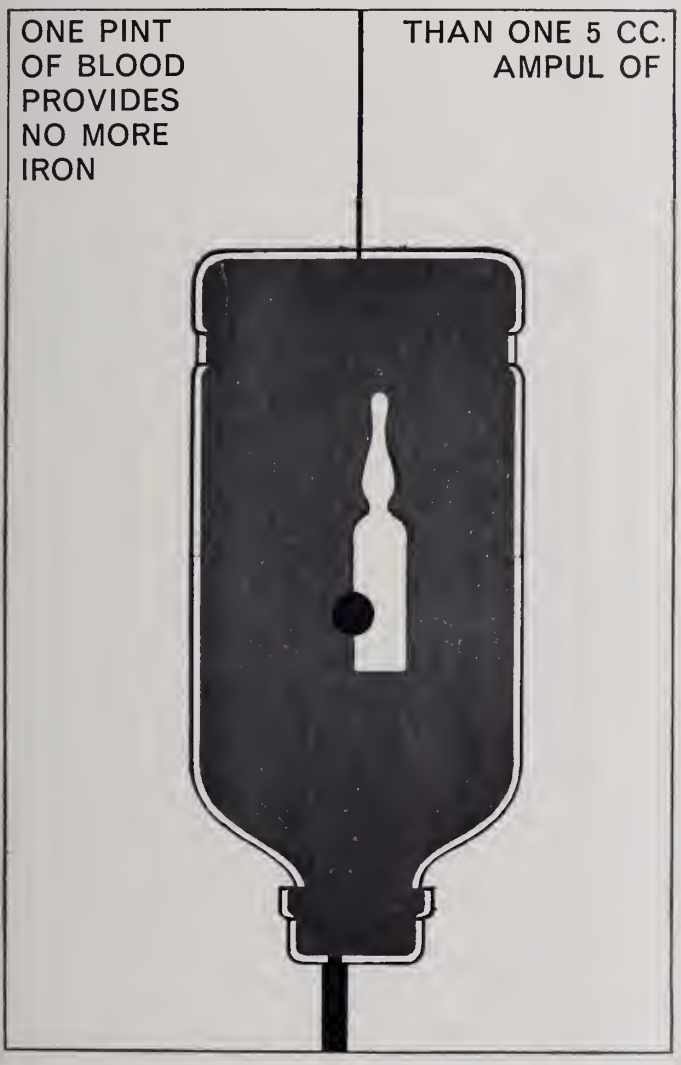
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* * *

"May I earnestly recommend, therefore, that general practitioners assume as a professional responsibility the obligation of recording their personal experiences with individual drugs. It is my hope that they will pass along their conclusions, based on collective experiences, to the companies who develop and produce those drugs. It is also my hope that they will pass along such data to the Food and Drug Administration when and if the occasion warrants. May I reiterate that as members of a great profession general practitioners have a responsibility not only to their patients today, but the patients of tomorrow and to the most important mission on earth, the discovery of new agents to conquer the still unconquered diseases that afflict mankind." Theodore G. Klumpp, M.D., in *GP*, (32:211), November 1965.

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SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

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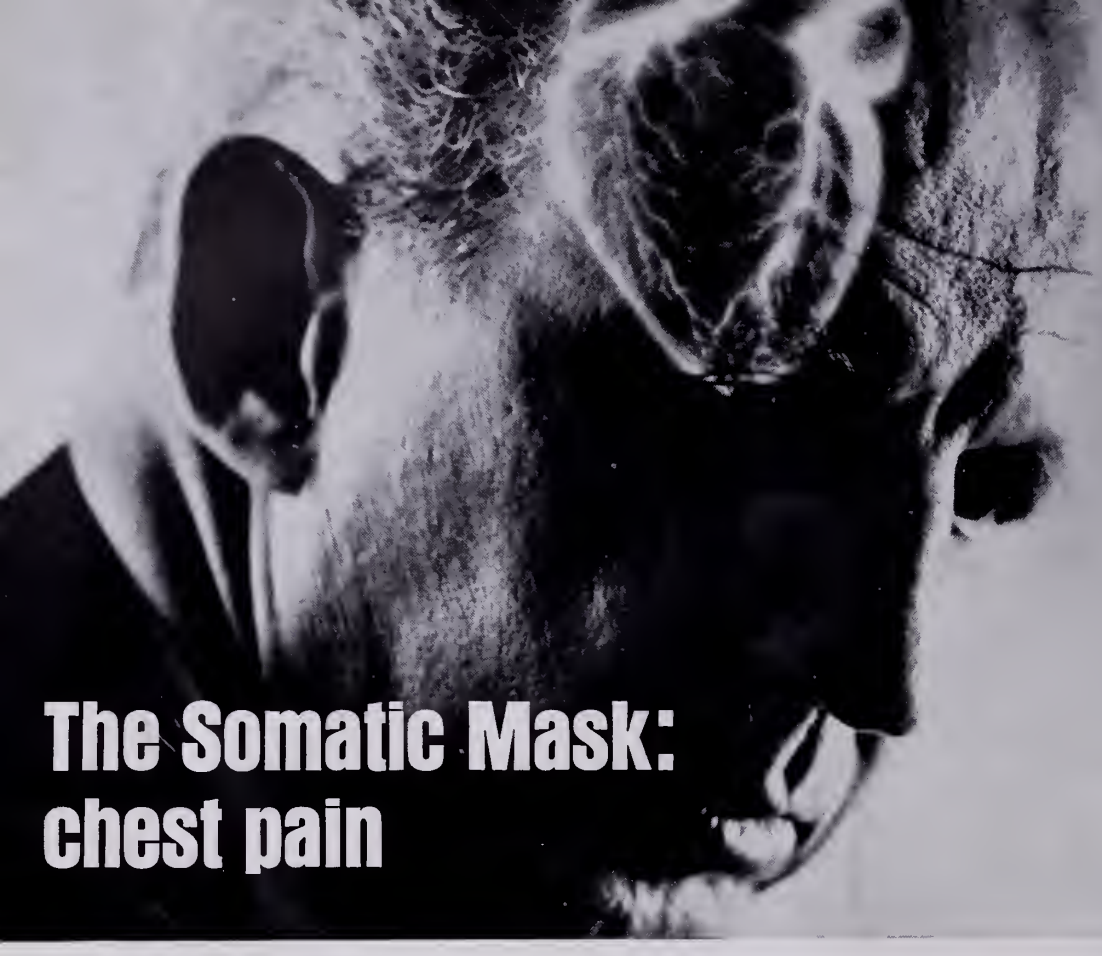
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Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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INDICATIONS: Grand mal epilepsy and certain other convulsive states.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced.
SIDE EFFECTS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Upon discontinuation of therapy eruptions usually subside. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Hematologic disorders, including megaloblastic anemia, leukopenia, granulocytopenia, pancytopenia, and aplastic anemia have been reported. Nystagmus may develop.
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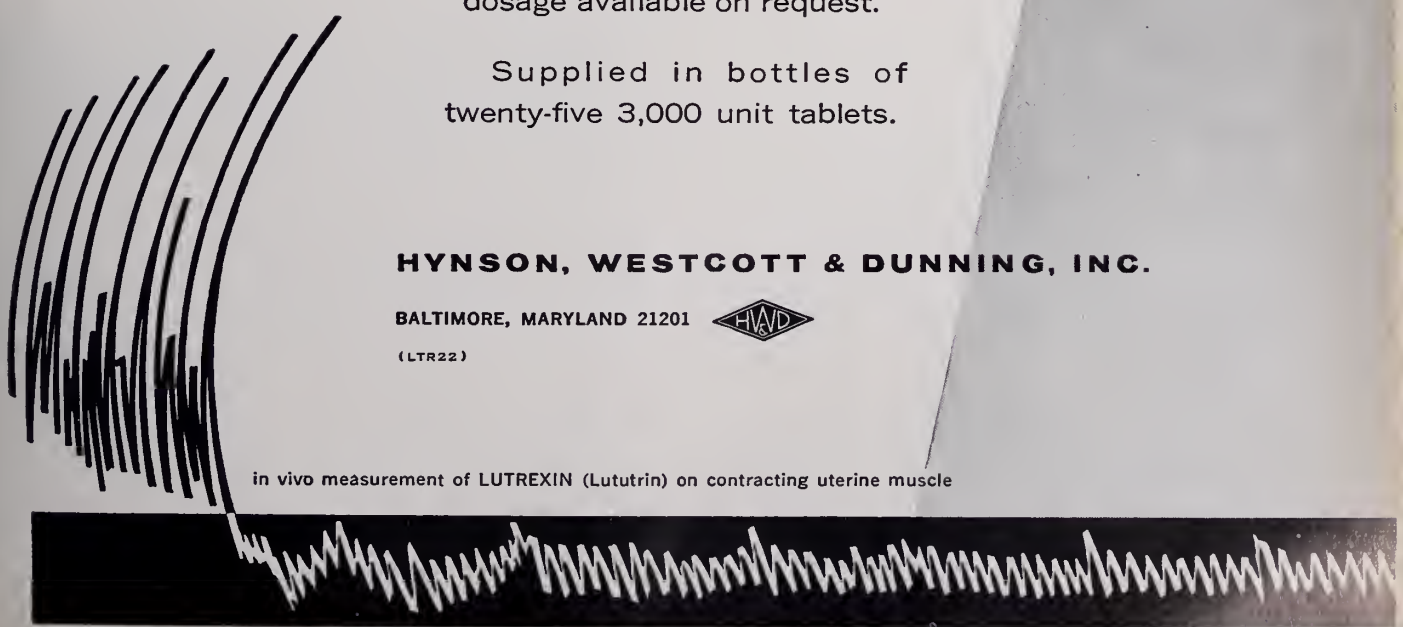
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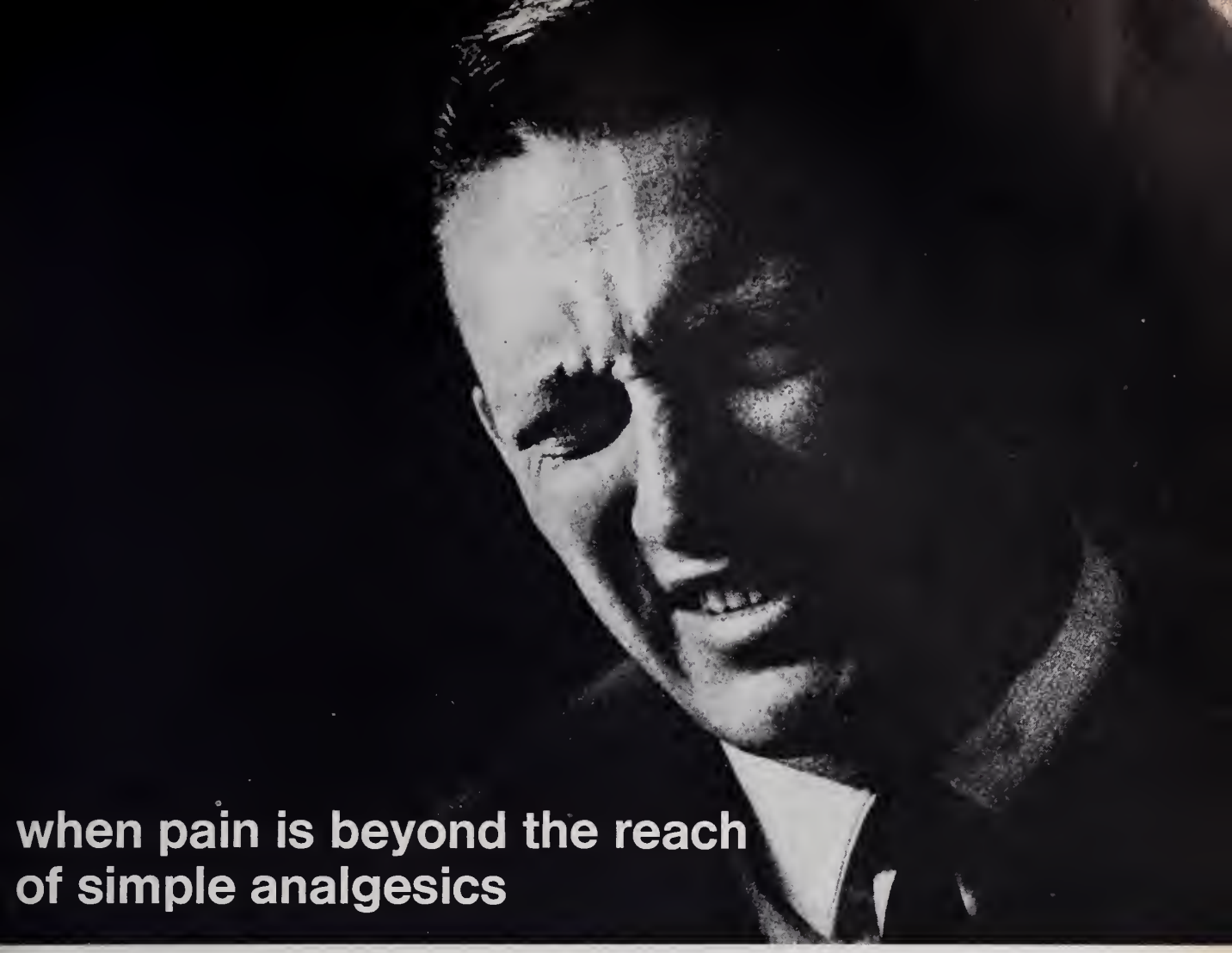
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1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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MESSAGE FROM THE PRESIDENT



Participate or ?

THIS is a timely subject when viewed in the light of the present Medicare Law. However, my subject of "Participation" deals with you and your local environment—specifically, your local medical society and the health problems of your community and state.

Many of the problems of medicine today have been brought on us because we, the physicians, were "too busy" to participate in local problems. We do not even attend our medical society meetings. Most medical societies feel fortunate to have 25 per cent attendance at their meetings and only about 10 per cent are willing to work. How can an organization possibly carry out any program for the betterment of medicine with such poor participation? It is impossible to obtain the feelings of the majority of the physicians of the community on a given subject because so few of them will take the time to participate. Yet, who is the first to criticize, and usually in loud tones, when the handful of men who are concerned take action on a specific problem?

I recently came across a paper written approximately 55 years ago by my wife's father, a physician in rural Boone County, Kentucky. The subject of the paper, in essence, was that physicians must join together in the comradeship of the county medical society to protect their patients against charlatans and quacks, and to educate themselves in the great strides taking place in medicine. He noted that the prestige of the physicians was strengthened by the activities of a strong medical society.

Our problems today are basically the same, only they are more complex. Advances in technical knowledge have brought about a high degree of specialization. Advances in the social economic culture have produced a third party in medicine which threatens complete socialization of the art of healing. Increasingly, it becomes more important that each of us actively participate in organized medicine.

Participate or Capitulate?

D. K. Dudderar, M.D.
Vice-President (Eastern)

†*This is the third in a series of four guest articles written at the request of KMA president Everett H. Baker, M.D., by the president of the Woman's Auxiliary and the three KMA vice-presidents.*



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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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FUNDAMENTALS OF CLINICAL HEMATOLOGY, Second Edition; by Byrd S. Leavell, M.D., and Oscar A. Thorup, M.D.; Published by the W.B. Saunders Company, Philadelphia and London, 1966; 597 Pages; Price, $12.50.

This book has been written with the practicing physician in mind.

The hematologic problems are described with simplicity yet fairly good completeness. Theoretical discussions are eliminated to the maximum extent. True case histories are presented for most diseases, an unusual and useful feature of this book.

A brief summary of hematology laboratory techniques is given.

The topic of blood banking theory is completely omitted from this publication. Some of the unusual hematologic conditions are also omitted or described only very briefly. The number of illustrations is limited.

G. Raccuglia, M.D.

MEDICAL PHARMACOLOGY, Third Edition: by Andres Goth, M.D.; Published by the C.V. Mosby Company, St. Louis, 1966; 634 Pages; Price, $12.50.

The author contemplating production of a textbook of pharmacology is in an unenviable position for the field is rapidly changing and draws material in both breadth and depth from a variety of disciplines. His efforts will generally follow one of two directions. He can choose to produce a large, all encompassing volume, that attempts to cover all aspects of the field in depth, or he can try to assemble a more concise volume with emphasis on general principles and concepts.

As in previous editions of his *Medical Pharmacology, Principles, and Concepts,* Andres Goth has chosen the latter direction in this third edition. The book begins with a discussion of the general principles of pharmacology which is remarkably clear and concise. About half of the remaining (over 300) pages in the volume are devoted to drugs which act on some aspect of nervous function, either autonomic or central. Almost one hundred pages are occupied with chemotherapy and antibiotics, leaving only about two hundred pages for the rest of pharmacology. This distribution is probably not as unbalanced as it may seem in view of the current preoccupation of physicians, pharmacologists, and drug researchers with tranquilizers, sedatives, antihypertensives, and antibiotics.

This reviewer was pleased to find that conciseness has not eliminated the frequent use of structural formulae to illustrate the drugs being discussed. Each chapter is accompanied by up-to-date references, including a list of review articles. This especially useful feature gives the reader an opportunity for further reading in depth if he is diligent enough to pursue it.

Doctor Goth's book also benefits from having only a single author. In a day when many texts are little more than loosely edited collections of chapters written by many different people, it is a pleasure to read a book presented in one style and from one point of view.

The success of the concise approach to a field as large as pharmacology is open to question, however. The student may desire a brief statement of basic principles to simplify the learning process, but the present attempt to satisfy this desire has resulted in a book which deals with most subjects in a superficial manner. I am not convinced that an adequate knowledge of anatomy can be gained from study of the skin alone.

Donald M. Thomas, M.D.

FERMENT IN MEDICINE: by Richard M. Magraw, M.D.; Published by the W. B. Saunders Company, Philadelphia and London, 1966; 272 Pages; Price, $6.50.

Among the many unnecessary books written recently, this one probably will not be outstanding among its fellows as they all rush, lemming-like, toward a well earned oblivion. The author states, "This book attempts a restatement of the nature and purpose of medical practice on the assumption that these have been obscured . . . " I believe the assumption is unwarranted, the restatement obscure and the attempt unsuccessful. The author also states, "It is by now commonplace to say . . . . ", but though he recognizes the commonplace quality of what he is to say, he says it.

Doctor Magraw has a free hand with the grand and sweeping statement, however tenuous its connection with fact, as, "Certainly the medical faculties of university medical centers have been generally unaware of and uninterested in the changes that are occurring." At the other extreme from this large fault is the small fault of lavish use of currently fashionable words such as "sophisticated", "explosion" and "hopefully", a style I think of as Neoflatulent.

A peculiarly objectionable feature of this book is the Jovian assumption of the author that the average doctor is discontented and frustrated and " . . . . tends to treat first his own anxiety by deciding what disease entity the patient has, rather than focusing on what bothers the patient." And then there is this odd statement, "To the degree that a physician has trouble in trusting another to serve as his doctor and therefore in assuming the role of the patient, we are justified in doubting his readiness to carry out the treatment of others in the way most conducive to their well being." This makes very little sense to me.

Having discussed the doctor and the patient and their relationship, the author goes on to a considera-

tion of the hospital and is a little more understandable. One sentence is too good not to quote, " . . . hospitalization may be unwisely and too lavishly applied, like an old fashioned flax-seed poultice."

The section on research and its many serious problems in its relations with medical education and medical care is good. The urge to discuss this is currently rather widespread. Whether anything will come of this other than a spate of words remains to be seen. The same applies to the discussions of medical specialization and coordination and the paramedical, supplemental medical professions. One cannot escape the feeling that if the state of medicine nationally is as ill as depicted by Doctor Magraw, then we, locally, are enjoying an uniquely felicitous professional climate.

Chapter 13 contains considerable information and a number of provocative questions and statements which give some new interest to the subject of health insurance.

"Automation", one of the most fascinating fermentations going on in medicine, should have gotten more space in the book, to my way of thinking. The difficulties of programming are greater than I had realized and the benefits of error-free consultation are apparently more distant in the future than I hoped.

In the final section on "Emerging Patterns of Medical Care and Practice", the author reiterates, "To the public, apparently, the most important consideration about medical care is the matter of cost and the mode of payment. As we have said, the quality of care is ignored or taken for granted by the public." I do not know how Doctor Magraw reached this conclusion but I do know it does not apply to the patients I see. I also think there are many well informed people who will take issue with his opinion that doctors and the American Medical Association ". . . . in matters of health . . . . have little effectiveness" as leaders. Nor do I accept his statement that "Organized medicine is for the moment weak and discredited . . . . "

In an Epilogue, Doctor Magraw makes like Mary Worth, admonishes us tenderly, pats our little bruises, tells us to blow hard and then urges us onwards and upwards. He seems to feel that we (doctors in the age group 45-55) are sulking, that "we may be said to be suffering a kind of unresolved grief reaction, for we are looking for something that has gone". Now, that well and truly does it.

JACK CHUMLEY, M.D.

* * *

There is a meaty kernel of truth in the story that pharmaceutical companies have to tell to doctors. Some of these companies have developed splendid laboratories for research. They spend millions of dollars a year looking for new drugs. And every year they are finding new drugs, some of which lower mortality rates, shorten illness, prevent disease or make life for the chronically ill more tolerable. The more ethical companies search diligently for the truth about the effects of their drugs and tell doctors plainly what they have found.—Harry F. Dowling, M.D., in *Emory University Quarterly;* (21:-98-99), Summer, 1965.



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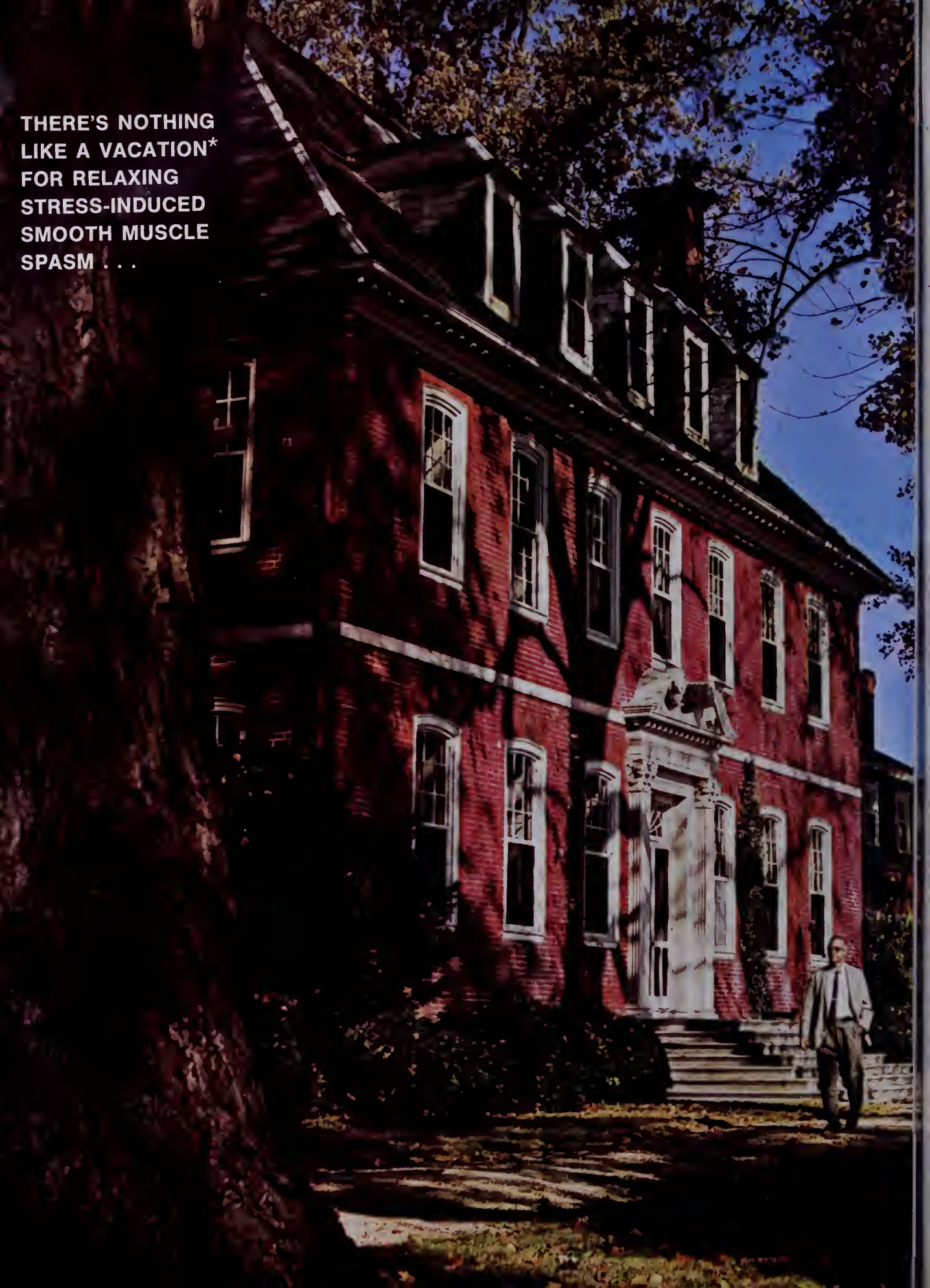
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There's nothing quite like a vacation to ease the pressures of the modern, "workingday" world. And for the patient who can't get away from it all, there's nothing quite like Donnatal to relax stress-induced smooth muscle spasm. For 31 years it has been the antispasmodic-sedative most often prescribed for relieving functional disturbances of tone and motility of the gastrointestinal tract.

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In Donnatal, natural belladonna alkaloids are rationally balanced in a specific, fixed ratio that provides "the greatest efficacy with the smallest possible dose."[1] They avoid the clinical uncertainties of the variable tincture and extract of belladonna, and are considered superior in range of action to atropine alone.[2] Furthermore, they are generally recognized as being more effective than the synthetics for relieving visceral spasm.

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Years of clinical use have established phenobarbital as one of the most efficient and highly regarded sedatives. In fact, for general sedation it is the drug of choice.[3] In Donnatal, phenobarbital potentiates the spasmolytic effects of the belladonna alkaloids, lessening emotional tensions and checking the neurogenic impulses that trigger GI disorders.

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Donnatal has withstood the test of time to become the classic sedative-antispasmodic because of its unsurpassed effectiveness, safety, economy, uniformity of composition, and dosage convenience. Its widespread acceptance and usage by the profession can also be attributed to its versatility in treating disorders characterized by smooth muscle spasm. There are more than two dozen distinct and separate indications for Donnatal listed in the current PDR.

IN EACH TABLET, CAPSULE, OR (5 cc.) OF ELIXIR

hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide ...	0.0065 mg.
phenobarbital	(1/4 gr.) 16.2 mg.

(warning: may be habit forming)

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hyoscyamine sulfate	0.3111 mg.
atropine sulfate	0.0582 mg.
hyoscine hydrobromide ...	0.0195 mg.
phenobarbital	(3/4 gr.) 48.6 mg.

(warning: may be habit forming)

BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

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Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their summer and fall meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky., 40205.

IN KENTUCKY

MAY

13-14	Kentucky Surgical Society Annual Meeting, French Lick Sheraton Hotel, French Lick, Indiana
14-15	Kentucky State Association of Medical Assistants Annual Meeting, Stouffer's Inn, Louisville
18-19	Kentucky Pediatric Society and Kentucky Chapter, American Academy of Pediatrics, joint annual meeting, Owensboro
25	KMA Twelfth Trustee District Meeting, Quality Court Motel, Somerset

JUNE

1	KMA Fifteenth Trustee District Meeting, Middlesboro
1	Professor's Day, University of Kentucky Medical Center, 8:30-4:30
3-4	Symposium on "The Use and Control of Radium in Medical Applications" co-sponsored by Kentucky Radiological Health Program and U. of L. Medical Center, at Rankin Amphitheater, Louisville General Hospital.
4	Anesthesiology Postgraduate Seminar, University of Kentucky Medical Center
8	KMA Third Trustee District Meeting, Madisonville
9	Kentucky Heart Association Annual Business Meeting, Louisville
14	KMA Sixth Trustee District, Bowling Green
16	KAGP Lancaster Seminar, Garrard County High School, Lancaster
30	KAGP Owensboro Seminar, Owensboro

JULY

20-21	KAGP Cumberland Valley Seminar, Du-Pont Lodge, Cumberland Falls

AUGUST

6-7	KAGP Elizabethtown Seminar, Holiday Inn, Elizabethtown
21	KAGP Bluegrass Seminar, Imperial House, Lexington

SEPTEMBER

20-22	KMA ANNUAL MEETING, Convention Center, Louisville

IN SURROUNDING STATES

MAY

15-18	Illinois State Medical Society, Sherman House, Chicago
22-25	American Thoracic Society, San Francisco Hilton Hotel, San Francisco
22-26	American Orthopaedic Association, Colorado Springs, Colo.
24-28	Ohio State Medical Association, Cleveland
26-28	American Gastroenterological Association, Drake Hotel, Chicago
30-June 1	American Ophthalmological Society, White Sulphur Springs, W. Va.

JUNE

2-4	American Gynecological Society, The Homestead, Hot Springs, Va.
9-11	Great Smoky Mountain Pediatric Seminar, Gatlinburg, Tenn.
23-27	American College of Chest Physicians, Sheraton-Chicago Hotel, Chicago
25-26	American Diabetes Association, LaSalle Hotel, Chicago
26-30	AMERICAN MEDICAL ASSOCIATION Annual Convention, Palmer House and McCormick Place, Chicago



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CANTIL®
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helps restore normal motility and tone

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function... Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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DACTILASE®

Each tablet contains:
Dactil® (piperidolate hydrochloride), 50 mg.;
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Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.
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In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

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Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

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Obstetrical or post—surgical patients requiring a dependable increase in hemoglobin will receive as much iron (250 mg. in a 5 cc. ampul) as in one pint of blood. Imferon (iron dextran injection) is less expensive and it avoids the well-recognized hazards of whole blood transfusion. When patients cannot—or cannot be relied upon to—take oral iron, Imferon (iron dextran injection) will rapidly supply needed iron for reserve stores.



IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*

METAHYDRIN®

(trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

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Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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Feelings of guilt, worthlessness, emptiness and loss frequently characterize depression. Such feelings, along with insomnia, physical complaints, sadness, apprehension, and other symptoms of depression rapidly respond to Norpramin (desipramine hydrochloride). Improvement often begins in 2-5 days, sometimes in less. A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Side effects, usually mild may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



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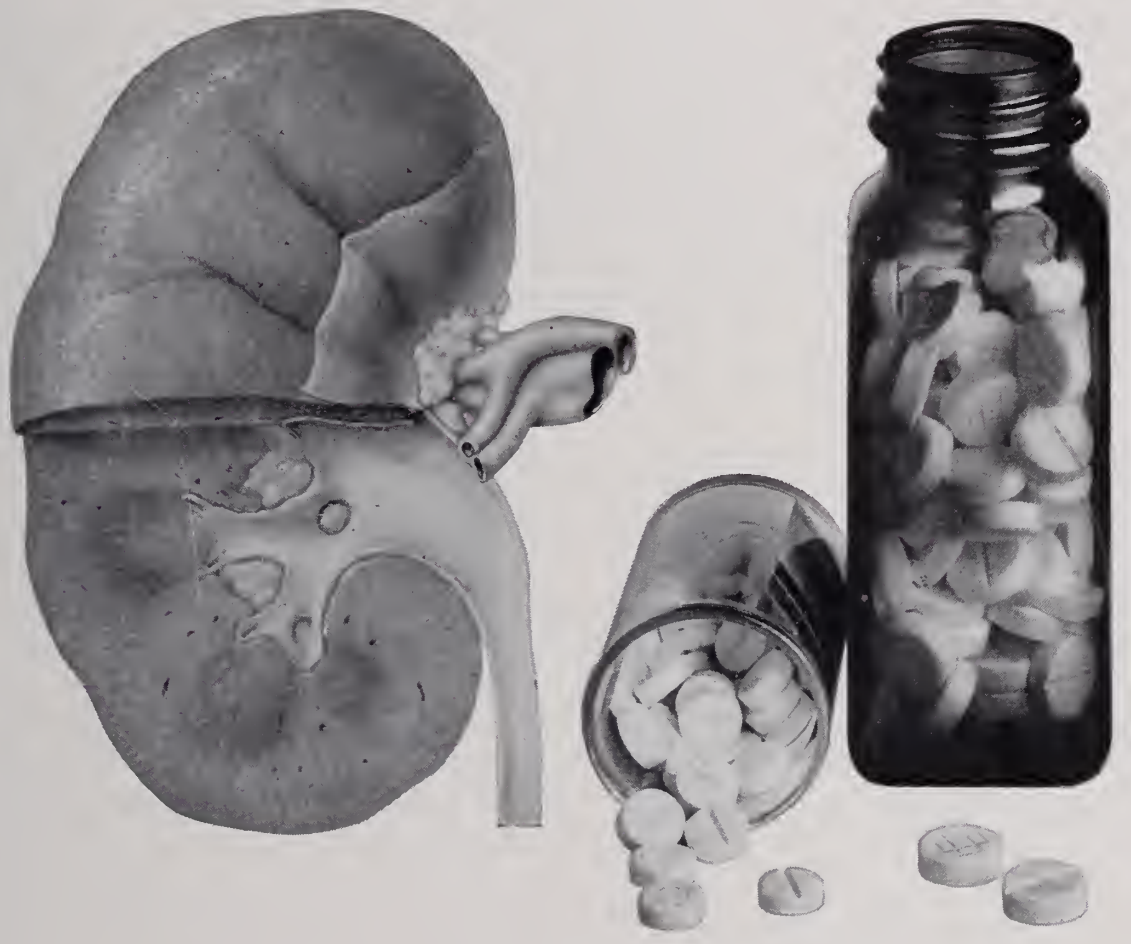
each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

PUBLIC HEALTH PAGE

Measles Vaccine

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

THERE IS much talk of apathy among the people of our nation today. A serious consideration for those concerned with the health of the nation's children is the "measles apathy". For years, the danger of measles (Rubeola) has been minimized, partly because there was no method of prevention and partly because people have perpetuated the myth that measles is a "harmless" disease.

The deaths from this "harmless" disease, however, have often exceeded those from polio. It has been estimated that one out of every thousand who contract this disease die. One out of six measles victims suffer complications such as pneumonia, ear infection, myocarditis, and encephalitis, which can result in permanent brain damage.

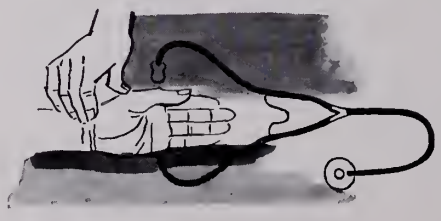
Measles attacks 95 per cent of the population. In Kentucky last year, 18,656 cases were reported. It is generally estimated that for every reported case of measles in the United States, ten cases go unreported.

Since March, 1963, when the Enders live-virus vaccine was made available, we have had the means of wiping measles out almost completely, just as we did with polio. This is possible, however, only if the nation's 20 million susceptible children are vaccinated. Only six million children have received the vaccine since it has become available.

In May, 1965, the Kentucky State Department of Health made available live measles vaccine (Schwarz strain) to county health departments throughout the State for use with children in the one to five age group. With the approval of the county boards of health, this vaccine may be administered at regular immunization clinics.

Measles begins its increase during January and becomes progressively worse for the next five months, usually reaching its peak during May. Epidemics, when they occur, strike the hardest in the lower socio-economic groups where nutrition and general health conditions are poor.

The people of our State and nation must become aware of the seriousness of this so-called "harmless" disease. Not using the measles vaccine is a reckless gamble with our childrens' intellectual growth and development which we cannot afford to take.







one mid-morning **one mid-evening**

New 300 mg tablet It's made for b.i.d.

For Adults–2 tablets provide a full 24 hours of therapy...with all the extra benefits of DECLOMYCIN...lower mg intake per day...proven potency... 1-2 days' "extra" activity to protect against relapse or secondary infection.

DECLOMYCIN®

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Duodenal mucosa with ulcer crater—
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Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

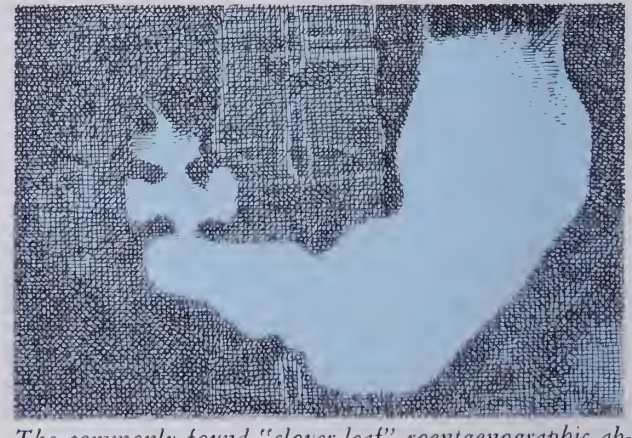
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

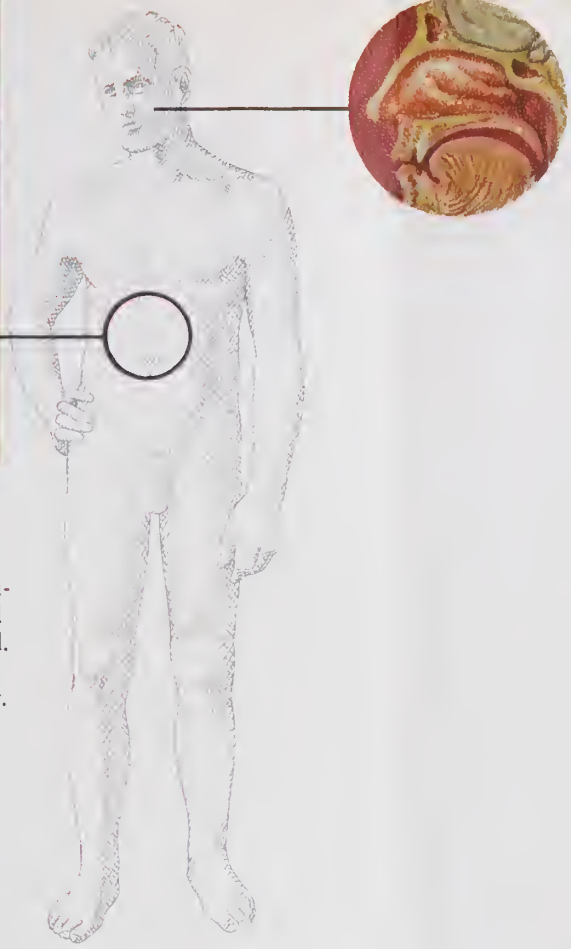
The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.





Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



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substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

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References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

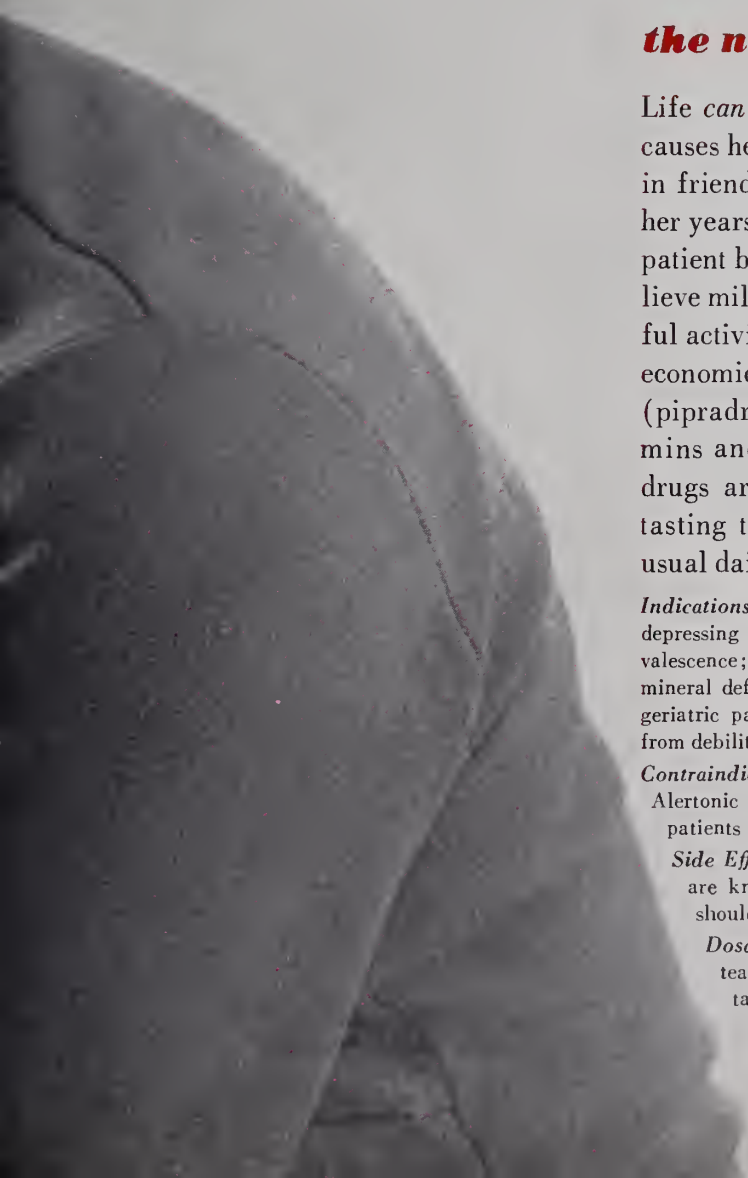
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Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

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Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Catheters, Bacteriuria and Pyelonephritis†

Richard Chute, M.D.*

Boston, Mass.

Many kidneys showing the morphologic picture of what was thought to be characteristic of chronic pyelonephritis due to bacterial infection are now considered to represent chronic interstitial nephritis not due to bacterial infection.

FOR THE title of this presentation I have chosen "Catheters, Bacteriuria and Pyelonephritis". This proves that I am either a very brave man or a very rash one, as there are few subjects in contemporary medicine about which so much has been written and about which there has been so much debate as chronic pyelonephritis. In very recent years there have been some important developments which have altered the thinking in this field, and which I would like to touch upon in this presentation.

Some years ago, my fellow Bostonian, Doctor Kass and coauthors, as a result of his investigations of bacteriuria, reported[1] that a bacterial count of at least 100,000 bacteria per milliliter of bladder urine indicated a significant urinary infection, whereas a lower count meant contamination rather than a true infection. This figure has been generally accepted.

Doctor Kass reported that the morphological picture traditionally signifying chronic pyelonephritis had been found in 17 of 100 consecutive autopsies. Of these 17 patients, 14 had bacteriuria of more than 100,000 per milliliter, while 3 showed no bacteriuria, which was a little puzzling. Another point of interest was that in these 17 patients showing the traditional microscopic picture of chronic pyelonephritis, a urinary infection had *never* been diagnosed clinically in 12 or 70 per cent of them. Kass explained this on the assumption that chronic pyelonephritis could be alive without giving the classical symptoms of fever, flank pain and dysuria, and that it could become a chronic infection, smoldering along and giving no noticeable symptoms, so that the diagnosis might be often missed. Another puzzling thing was that, in these 100 autopsies, while 40 patients had bacteriuria of 100,000 or more, only one-third of the forty showed microscopic pyelonephritis. Despite these various unexplained discrepancies, Kass came to the conclusion that one-third of patients with bacteriuria of 100,000 or more also had associated chronic pyelonephritis. He admitted that, while there was no direct evidence that an infection in the bladder usually ascended to the kidney and caused pyelonephritis, he could not help but believe that this did occur. He also recognized, as has been known by urologists for a long time, that obstruction and resulting stasis in the urinary tract, foreign bodies and calculi, not only predispose to the development of infection, but also interfere with its eradication, so that it may become chronic.

Among the various causes of urinary tract

†*Presented at the Second General Scientific Session of the Kentucky Medical Association Annual Meeting at Louisville September 21-23, 1965.*

**Chief, section of urology, Veteran's Administration Hospital, Boston, and clinical professor of urology, Boston University School of Medicine.*

infection, which Kass felt frequently led to chronic pyelonephritis, were urethral instruments such as catheters, and especially inlying catheters. He found that the placing of an inlying catheter was very soon followed by an infection of the bladder — and within 96 hours in 95 per cent of patients. The infection occurred despite the administration of potent urinary antiseptics, which were powerless to prevent the occurrence of the infection. Doctor Beeson[2] of Yale joined Kass in publicizing the catheter as a pathway by which infection entered the urinary tract, and agreed with him that, in a high percentage of cases this infection ascended from the bladder to involve the kidneys where it frequently became established. Once established, they agreed that it was apt to become almost impossible to eradicate, and often went on to serious incurable chronic pyelonephritis.

Therefore, as a result of the writing of Doctors Kass, Beeson and others, the catheter, traditionally hailed as a bringer of relief to suffering mankind, has been under a cloud in recent years, and we urologists have often been criticized for using it too freely. However, not only does the urologist have to use a catheter in connection with prostatic and bladder surgery, but there are also many occasions when the general surgeon, the gynecologist, the neurosurgeon, the orthopedists — and sometimes the internist—find it necessary to use a catheter. For this reason, I have become interested in this problem, and have gathered some evidence showing that the placing of a catheter is seldom the "kiss of death". In my opinion, Doctor Kass' and Beeson's greatest contribution was to call attention to the great frequency with which patients with inlying catheters contracted bladder infections. However, the evidence will show that they greatly overestimated the frequency with which infections in the bladder ascended to involve the kidney and cause serious chronic pyelonephritis. Nevertheless, their writings and opinions have become accepted by much of the medical world.

Inlying Vs. Intermittent

However, the urologists from their extensive experience with patients on inlying catheter drainage, knew that, although such patients practically always get an infection of the bladder urine, *if* obstruction and stasis and stone are remedied, and the patient is given the appropriate therapy, the urinary infection eventually disappears, and the patients seldom develop pyelonephritis.

If catheterization is necessary for more than two days, an inlying catheter is preferable to intermittent catheterizations. Intermittent catheterizations are impractical as they do not supply really free urinary drainage, and the urethra is apt to soon become inflamed and often difficult to catheterize, and it has been found that bladder infection follows a series of intermittent catheterizations as surely as it appears with an inlying catheter. Furthermore, and I consider this to be very important, in a patient who is being catheterized intermittently, once the urine has become infected if, for any reason, the patient is not catheterized in time and his bladder becomes over-distended (and sooner or later this is very apt to happen) he will very probably have an attack of acute ascending pyelonephritis with a high fever, flank pain, and bacteremia. He will get quite sick from this and, especially if he is aged and frail, it may take him a long time to recover and sometimes he will not recover. I have seen this happen a good many times in recent years since the use of inlying catheters became so abhorrent to the medical profession. In such a case, in my opinion and that of those of my urological colleagues with whom I have talked about this matter, the use of an inlying catheter which will provide free drainage at all times, even though it introduces a bladder infection, is far preferable to intermittent catheterization which also introduces a bladder infection but does not furnish constant free drainage and usually ends up with an episode of acute obstruction followed by a case of fulminating acute pyelonephritis, dangerous to the patient especially if he is old and frail.

Does Infection Become Incurable?

As regards the proposition that once the bladder becomes infected the infection will probably ascend to the kidney where it will probably cause a chronic, perhaps incurable, pyelonephritis, let me adduce the following evidence.

Clarke,[3] the former director of urology at Tufts Medical School, and his co-worker, Joress, made careful cultures of the bladder urines of 78 patients who had had various bladder operations from three months to five

and a half years previously. All of these had had indwelling catheters for from two to seven days after operation. Bearing in mind Kass's findings that after twenty-four hours 50 per cent of patients with inlying catheters acquired an infection of the bladder, and after four days almost 100 per cent did, it seems probable that most of these patients acquired a bladder infection at the time of their surgery. In their follow-up, Clarke and Joress found that 26 patients had sterile bladder urine, and another 51 showed less than 1000 bacteria per milliliter (considered definitely not significant by Kass) and only one of these 78 patients showed definitely significant infection remaining. Clarke felt that the low incidence of persistent bacteriuria was due to operative removal of obstructions, stasis and calculi, plus persistent follow-up with adequate and appropriate treatment of the infection until it had been eradicated.

Durham, Shooter and Curwen of St. Bartholomew's Hospital in London reported that 90 out of 102 women undergoing vaginal repair operations in 1953 developed urinary infections ascribed mostly to inlying catheters but also to repeated catheterizations. Of these 90 patients 82 received treatment at the time, and 73 of these patients had had at least one sterile urine culture on discharge. This left 17 of the 90 originally infected patients who were known to be infected on discharge in 1953. Nine years later two of the same authors, Curwen and Shooter, with Cattell and Williams of the same hospital, checked[4] on all but three of these original 102 patients regarding the status of their urinary tracts. They re-examined 71 of the patients as to urinary culture, blood urea nitrogen, serum creatinine and blood pressure. Seventeen other patients were reported by their own doctors, and ten were known to be dead. Of these ten, two each died of fractured skull, myocardial infarction, congestive heart failure, with sterile urine and no rise in blood pressure, and of cerebrovascular accident. One died of carcinoma of the breast, and one of diabetes and nepthosclerosis.

One case, known to have calculi before her vaginal operation and to have infection on discharge, still had the calculi and the infection, but had developed no signs of renal failure or hypertension, three other cases uninfected on discharge, were found to have infection, but also no signs of renal failure or hypertension. These authors came to the conclusion that, "This survey has not shown any example of a patient suffering from chronic or recurrent infection of the urinary tract with progressive renal damage as a result of catheter-induced urinary infection some nine years before. In catheter-induced infections in women, usually patients are able to eliminate the organisms responsible. To get the infection established some factor such as local obstructing abnormality of the urinary tract or diabetes must be necessary. From this study it appears that if an infection occurs and is treated, the majority of patients are unlikely to suffer permanent renal damage."

Does Infection Ascend?

Another piece of evidence was given by Morales and Tsou[5] at New York University who studied the bacteria in the bladder urine and in the urine from the kidneys of 10 paraplegic patients, all of whom had been on prolonged inlying catheter drainage at one time and had had proven bladder infection. Five patients were still on inlying catheters, and five had achieved voiding and were without catheters. Two of the patients who had achieved voiding had sterile bladder and kidney urine. Of the remaining eight patients (five with inlying catheters and three without), all of whom had a bacterial count of from 1 million to 200 million per milliliter of *bladder* urine, five had sterile urine from their kidneys, two had bacterial counts of less than 73,000 on their kidney urine (classified by Kass as contamination and not significant of a true infection) and only one had a high bacterial count on the kidney urine. Thus, these different authors have shown that: 1, chronic bladder bacteriuria usually does not ascend to involve the kidneys, and 2, that with complicating factors remedied, and with proper treatment, bladder infections can be eradicated in most cases.

My former associate, Doctor Leonard Zinman,[6] studied 12 patients with well-documented bladder bacilluria which had been known to be present for at least two years in every case. Intravenous urography and blood urea nitrogen levels were normal on all of these patients. Specimens of kidney urine (bilateral in six cases and unilateral in six cases) were obtained for culture from these 12 patients either by direct needle aspiration of the renal pelvis through the flank or at operation. *In nine of these patients,* known to have chronically infected bladder urine, no growth of bac-

teria was obtained from the urine from their kidneys.

The message that one gets from all these reports is that unless they have obstruction or stone, and sometimes even when they are not treated thoroughly, most of the patients with acquired bacteriuria do not go on to serious chronic pyelonephritis but eventually achieve sterile urine. This also corroborates the clinical impression which a urologist gets in the follow-up clinic where one notes that a high percentage of those who acquired a bladder urine infection at the time of their bladder or prostate surgery (and have been treated for it) have a clear urine after some months.

George Gee Jackson[7] and co-workers of the University of Illinois reported that of 33 renal biopsies which showed chronic pyelonephritis morphologically, only 30 per cent had positive bacterial cultures. They also reported that in another series of 16 renal biopsies from patients with infected bladder urine, only four (25 per cent) showed renal infection. Of the other 12 biopsies which gave a negative culture, all but one showed the tubular or inflammatory tissue changes traditionally supposed to be characteristic of pyelonephritis. Jacobson and Newman[8] of George Washington University had similar results. Of 63 renal biopsies, 26 showed morphologic changes consistent with pyelonephritis, but bacteria were found in only two of these 26. These findings indicate that there is little evidence to support the traditional concept that *only* bacterial infection can cause the inflammatory changes in the renal parenchyma to give the morphological picture of what has been considered pyelonephritis since the days of Longcope's paper in 1933. This raises the question as to just what is the nature of the process that causes these inflammatory and interstitial changes noted in the kidney?

Etiology Not Always Bacterial

Kleeman and Freedman,[9] at the beginning of what I consider a very significant paper state, "Although pyelonephritis has been defined as the pathologic alterations (in the kidney) which occur subsequent to the multiplication of pathogenic bacteria, patients with this diagnosis commonly do not give a history of urinary-tract infection and may have urine cultures that are repeatedly sterile. In addition, since these pathologic alterations may be found in kidneys with other diseases, their mere presence does not demonstrate that bacteria contributed to their development . . . The present study represents an attempt to investigate the etiologic relation between clinical urinary tract infection and the autopsy finding of chronic pyelonephritis."

One of the authors, Freedman, using quantitative bacteriologic techniques, had previously found infections of the bladder urine in clinic patients, in the absence of obstruction, to be ten times more common in women than in men. Therefore, he argued, if such infections of the bladder urine led to chronic pyelonephritis, one would naturally expect to find chronic pyelonephritis at autopsy, again in patients without obstruction or stone, ten times as often in women as in men.

Kleeman and Freedman reviewed the protocols and the microscopic slides of 1526 consecutive autopsies at the Grace New Haven Hospital. Excluding those cases where obstruction existed, they found 53 cases diagnosed histologically as pyelonephritis, and also 19 cases of "scarred" contracted kidneys with poor function and an elevated N.P.N. in whom the diagnosis of chronic pyelonephritis might have been overlooked. Although a history of previous urinary tract infection was far commoner in women than in men, at autopsy these diseases were found to be distributed about equally between the sexes.

This discrepancy between the great female preponderance of urinary tract infection, and the approximately equal sex distribution of chronic pyelonephritis found at autopsy may be explained by accumulated evidence that histologic changes quite similar to those of chronic pyelonephritis may result from diseases other than bacterial infection of the kidney.

A number of recent papers have reported the production of sterile chronic interstitial nephritis, indistinguishable morphologically from chronic bacterial pyelonephritis, by a number of different factors. One of the most common of these is the long-continued ingestion of excessive amounts of analgesic compounds containing phenacetin for the relief of chronic headache or the chronic pain of arthritis.[10] Other factors producing this picture are hypertensive vascular disease, especially malignant hypertension, the arteriosclerosis of old age, the later stages of acute tubular necrosis, obstruction and sterile hydronephritis, diabetes,

potassium deficiency, renal ischaemia, drug sensitivity as to a sulfonamide, immunologic reactions, or poisoning from a metal such as lead. Thus there have been shown to occur a variety of kinds of injurious processes other than chronic bacterial infection whose morphologic and functional consequences cannot at the present time be distinguished from those resulting from infection. The extent to which these non-infectious processes contribute to the total picture of so-called "chronic pyelonephritis" is currently one of the major questions in the field of renal disease.

In this connection approximately 63 per cent of the women and 57 per cent of the men in Kleeman and Freedman's 53 cases of histologic chronic pyelonephritis without abnormality or obstruction of the genito-urinary tract had hypertension. Also pertinent to this discussion was the fact that although one-third of the 28 women in the "chronic pyelonephritis" series had a past history of urinary tract infection, none of the 25 men in the series gave a history of a previous urinary tract infection, thus supporting the possibility of a nonbacterial etiology of the lesions observed. In my opinion, this paper of Kleeman and Freedman's is a very important one indeed, as it raises serious doubts about the validity of the microscopic diagnosis of chronic pyelonephritis in the absence of demonstrable bacterial infection.

A similar opinion is expressed in an excellent paper[11] on the chronic pyelonephritis problem by Pawlowski, Bloxdorf and Kimmelstiel, the celebrated professor of pathology at Marquette, who found the morphological picture of so-called chronic pyelonephritis in approximately 3 per cent of nerly 4600 autopsies. Only in a relatively small number of cases (14) could chronic pyelonephritis be related directly to bacterial infection found in the kidney. In the majority of cases (112) which were morphologically classified as "chronic pyelonephritis", no correlation between morphology and bacteriologic findings in kidney and urine could be established. The authors concluded by stating, "Morphologic manifestations of chronic bacterial pyelonephritis, including the presence of neutrophils, are indistinguishable from those of non-bacterial interstitial nephritis. Without corroborative clinical or bacteriologic evidence, we cannot be certain whether non-bacterial interstitial nephritis is a sequela of an initial bacterial infection *or* represents a patho-genetically different disease."

Kimmelstiel in another paper,[12] as a result of the careful microscopic examination, tissue culture and urine culture of 200 kidneys at autopsy, reported, "These data indicate that in the majority of our cases morphologically diagnosed as chronic pyelonephritis, using strict criteria, no bacterial origin could be demonstrated and no correlation to bacteriuria could be established. In only a small group of cases (7 percent) was it possible to correlate the histologic findings with positive cultures of renal tissue and bacteriuria."

In other words, many of the cases which have been diagnosed in the past as "chronic pyelonephritis" were probably not chronic pyelonephritis due to bacterial infection, but were chronic interstitial nephritis due to something else. This would help explain Kass's failure to find bacteriuria in two-thirds of 40 cases of supposed "chronic pyelonephritis" discovered at autopsy. Therefore one feels that many of the original cases of Kass, of Beeson and of others, supposed by them to be "chronic pyelonephritis" due to bacterial infection, *but* where bacteria could *not* be found, were really cases of chronic interstitial nephritis due to some cause other than bacterial infection.

Conclusions

The conclusions to which I have come as the result of the evidence I have found are as follows:

1. The use of the inlying catheter, which gives constant, free, obstruction-less urinary drainage is preferable to repeated intermittent catheterizations, which often lead to an attack of acute pyelonephritis.

2. The use of the inlying catheter in the past has almost always led to an infection of the bladder and bacteriuria.

3. Bladder infection, in the absence of stasis due to obstruction, or stone, usually does not ascend to cause infection of the kidneys and therefore the finding of bacteria in the bladder urine does not usually signify a renal infection.

4. Bladder infection, in the absence of obstruction, etc., is eradicated by the proper medication in the vast majority of cases, and sometimes clears up spontaneously without medication.

(Continued on Page 450)

A Comparison of Intrathecal Alcohol and Phenol†

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Sixty-two patients received absolute alcohol or five per cent phenol in glycerin in the subarachnoid space below T 12. Both drugs produce effective prolonged pain relief. Alcohol impairs sphincter control significantly more often than phenol.

THE CANCER patient whose disease is too widespread to be cured or palliated by surgery, radiotherapy or chemotherapy can often benefit from chemical rhizotomy.

Since 1930, when Dogliotti[1] administered absolute alcohol intrathecally, and 1955 when Maher[2] reported the use of phenol by the same route, there have been many reports[3],[4] of the use of these two drugs for the relief of intractable pain. However, the efficacy and hazards of these drugs have not been evaluated in a comparable series of patients. It is the purpose of this paper to compare the results from absolute alcohol and 5% phenol in glycerin administered intrathecally in the lumbosacral region for the relief of pain from malignant disease.

Case Material and Methods

Sixty-two patients received intrathecal blocks below the twelfth thoracic nerve, 20 with alcohol, 38 with phenol and four with alcohol once and phenol once. These patients had advanced cancer, were not responding to chemo or radiotherapy and were receiving narcotics in doses as high as 750mgm. of morphine per day. Both drugs were administered in doses of approximately 0.5 to 1.0ml per segment to be blocked. The highest dose of alcohol during a single procedure was 3.0ml. and that of phenol was 2.0ml. The same neural elements were blocked with each drug, namely the dorsal roots as they passed through the dural sleeve near the intervertebral foramina.

Results

The results were evaluated as follows:
(a) Good—When the patient stated that the pain was completely relieved. This relief had to last for at least two weeks or until death.
(b) Moderate—When the patient stated that a significant portion of the pain was gone for at least two weeks. The net result must be more activity, or less potent and less frequent narcotics requirement, or greater comfort from analgesics.
(c) Poor—When little or no relief of pain was obtained, or when relief did not persist for more than two weeks.
(d) Inconclusive—When, for a variety of reasons, evaluation of pain relief was not reliable.

Most of the patients receiving intrathecal blocks had been receiving narcotics, and psychic or physical dependence on the drug was not unusual. Therefore, the amount of narcotic required the first few days after the block was not a reliable index of effectiveness.

The results are reported per patient rather than per block. For example, if a patient had one unsatisfactory block and a second block relieved all the pain, the result is listed as good for that patient. Table I compares the results of the alcohol and phenol blocks. The four patients who received one block with each drug are included in each group. The patients with good and moderately good relief of pain are combined to calculate the percentage of satisfactory results. There was satisfactory relief of pain in 12 of the 24 patients (50%) receiving intrathecal alcohol compared to 31 of the 42 patients (74%) receiving phenol. When these figures are analyzed for probability by the Chi Square Method, phenol is not significantly more effective

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Table I

ANATOMIC SITE OF BLOCK AND RESULTS

SITE OF BLOCK	ALCOHOL RESULTS Total	Good	Mod.	Poor	?	PHENOL RESULTS Total	Good	Mod.	Poor	?
Thoracolumbar	1	1				1	1			
Lumbar	7	1	1	3	2	18	7	7	2	2
Lumbosacral	6	2		3	1	16	8	2	3	3
Sacral	10	5	2	2	1	7	3	3		1
Total	24	9	3	8	4	42	19	12	5	6
		12					31			

$\frac{12}{24}$ = 50% Satisfactory results $\frac{31}{42}$ = 74% Satisfactory results

than alcohol in the relief of pain. ($p<0.05$) When relief of pain was obtained, it usually persisted until death. In the alcohol group this varied from nine days to seven and one half months, and in the phenol from one day to 22 months. Pain recurred in four of the satisfactory phenol group after one month in two cases and after two months in two cases. There were no recurrences of pain in those blocked with alcohol who had good results.

Of the 62 patients, 22 received more than one block. (See Table II) Eight patients were reblocked because of unsatisfactory pain relief initially, four from the alcohol and four from the phenol group. The second blocks resulted in pain relief in four of the eight patients. Twelve patients were reblocked on the opposite side or for a different area of pain or both. Two of the four patients whose pain recurred were reblocked. No patient received a third block after two unsuccessful blocks.

Complications

Table III indicates the incidence and nature of the complications with the two drugs. Of the 16 patients who had intrathecal alcohol injections in the area of sacral nerves, six had pre-existing sphincter abnormalities. Of the remaining ten, six (60%) patients developed permanent urinary or rectal problems, and one of these had both. Of the 23 patients blocked with phenol in the sacral region, eight had pre-existing sphincter abnormalities and two of the remaining 15 patients (13%) developed permanent urinary retention after the block, one developing rectal incontinence as well.

Persistent hypesthesia after both phenol and alcohol can be as unpleasant as the previous pain. This occurred in four cases, two with alcohol and two with phenol. An additional 12 cases (5 with alcohol, 7 with phenol) had persistent hypesthesia that was not intense enough to be a problem.

In two (8%) of the patients blocked with alcohol, and in seven (17%) of the patients blocked with phenol there was increased muscle weakness after the block. In one of the alcohol cases and in three of the phenol cases, this muscle weakness was incapacitating.

Paresthesia, arachnoiditis, signs of spinal cord transection, and epileptiform seizures occurred separately in four patients.

The paresthesia developed nine days after an otherwise successful phenol block. The original ischial pain was permanently relieved but the "burning" in the patient's legs was disabling and the result is listed as poor. The paresthesia was likely due to progression of tumor but this was never proven.

Chemical arachnoiditis developed in a 27

Table II

INCIDENCE OF MULTIPLE BLOCKS

Reason for Reblocking	Initial Block with AA	Initial Block with P/G
Inadequate relief of pain after first block	4	4
Pain in a different site from that initially blocked	7	5
Recurrence of pain after initially satisfactory relief		2
Total number of patients blocked more than once	11	11
Total number of patients	22	40

Table III

INCIDENCE OF COMPLICATIONS

	Alcohol (24 pts.) Temp.	Perm.	Phenol (42 pts.) Temp.	Perm.
Urinary retention	1	5	4	1
Fecal incontinence	1	2		2
Hypesthesia	1	7	5	9
Muscle weakness		2		7
Paresthesia			1	1
Arachnoiditis			1	
Other neurological		2?		

year old man two days after phenol block and persisted for two and one-half weeks. After discharge he returned to work for the first time in several months and has persistent relief of pain 22 months after the block.

The spinal cord damage occurred in a 64 year old man with metastatic disease in his spinal cord who was blocked twice with alcohol, for pain on the left at an L3-T10 distribution and on the right at a T12-T9 level. Although his pain was relieved, he gradually developed increasing signs of ascending cord damage, and 25 days after the block he had a paraplegia below the level of T10. No autopsy was performed to determine whether this was due to progressive disease or to the block.

One 73 year old man who had good relief of pain after alcohol block had two grand mal seizures within ten days. The cause was believed to be cerebral atrophy secondary to generalized atherosclerotic vascular disease.

Discussion

Effective relief of intractable cancer pain can be achieved with intrathecal alcohol or phenol.

The incidence of post injection sphincter impairment was the only significantly different factor between the two drugs. Ten patients with intact sphincters had alcohol block of sacral nerves. Four of these developed permanent urinary retention, one developed permanent rectal incontinence and one developed both. Fifteen patients with intact sphincters had phenol blocks of the sacral nerves. Of these two had permanent fecal incontinence, one of the two having urinary retention as well. The advantage of phenol's sphincter sparing as compared to alcohol is significant when analyzed by Chi Square, ($p < 0.02$).

A significant factor effecting the results from intrathecal blocking agents is the group of patients in whom the results cannot be evaluated. (16% of both phenol and alcohol series). In all of these patients there were signs of relief, such as greater activity, or longer intervals between doses of narcotics, and yet the patient denied any benefit from the block. Because many patients with advanced disease become emotionally exhausted from their long illness and look forward to the nerve block as a "cure" for their disease the attainment of pain relief only is unsatisfactory to them. The disappointment with the limitations of the block may result in a depressed or withdrawn patient who denies any benefit despite the lessened requirement for narcotics.

Conclusions

1. Both absolute alcohol and 5% phenol in glycerin in the subarachnoid space produce equally prolonged, effective relief of intractable pain in patients with advanced cancer.
2. When sacral nerves are blocked, alcohol impairs sphincter functions more often than phenol ($p < 0.02$).

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Iatrogenic Gout†

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Lexington, Ky.

Acute gouty arthritis may be produced by drugs, diets, and therapeutic procedures. An erroneous diagnosis of gout may be made in rheumatic disorders if too much emphasis is placed on an elevated uric acid.

Introduction

GOUT IS A disorder of uric acid metabolism characterized by hyperuricemia, recurrent attacks of acute painful arthritis, and in the late stages by a chronic deforming arthritis with deposits of urate in the bone, cartilage and soft tissue. It may occur in a primary or secondary form. Primary gout is thought to be an hereditary disorder; a family history can be obtained in about twenty percent of patients. A secondary form of gout may result as a complication of certain diseases, particularly blood dyscrasias such as polycythemia vera and chronic myelogenous leukemia. The characteristic feature in the history of gout is that for many years the arthritis symptoms disappear completely between acute episodes. Usually there is involvement of a single joint initially with multiple joint involvement later. There is a tendency for subsequent attacks to become more frequent. Eventually chronic tophaceous gouty arthritis with multiple joint deformity may occur.

About 95 per cent of cases occur in males and usually after the age of thirty-five. When gout occurs in women, it almost always occurs after menopause. One should be most reluctant to make the diagnosis of gout in a menstruating woman.

In about 70 per cent of patients the first attack of gout involves the great toe. Other sites which are frequently affected are the instep of the foot, the heel, the ankle, and the knee. The smaller peripheral joints, especially those of the lower extremities, are involved far more often than the larger proximal joints. It is most unusual to have involvement of the shoulders or hips in the early stages of gout.

The clinical features of gout permitted this disease to be distinguished from other types of arthritis relatively early in the history of medicine. In fact, the first description of gout has been attributed to Hippocrates in the fifth century B.C. Colchicine, the specific remedy for the acute attack, has been used since the sixth century A.D.[1] During this time gouty arthritis has attracted the interest of historians of medicine and chemistry alike since many prominent leaders of the past have been victims of this malady.

In spite of this long heritage and awareness of gout, more has been learned about gout during the past decade than in the previous centuries. Mechanisms concerning the production of the hyperuricemic state, hypotheses as to the cause of the acute episode and the action of colchicine, and measures for the control and resorption of tophi have been intensely studied and reported during the past ten years. Perhaps, because gout is now believed by many to be one of the few treatable forms of arthritis, physicians seem somewhat overanxious at times to make the diagnosis and institute treatment. Unfortunately, in many cases joint pain plus hyperuricemia have produced colchicine and probenecid almost automatically. This may occur even if the initial episode of pain occurs in the shoulders, hips, or spine—joints which are rarely affected by gout. Gout has also been noted to occur following treatment with some of the newer drugs, special diets, and specific hematologic procedures. Iatrogenic gout, therefore, may occur by:

Producing gout when it is not there
Producing gout with new drugs
Producing gout by diet
Producing gout after hematologic procedures.

Producing Gout When it is not There

A 28-year-old white male noted the acute onset of pain in the left shoulder in September 1959. An X-ray was negative; the uric acid

†*Presented at the September 30 meeting of the Kentucky Chapter of the American College of Physicians at the KMA Annual Meeting in Louisville, September 29-October 1, 1964.*

**Consultant in Medicine at The Lexington Clinic, Lexington, Ky.*

Flagyl destroys trichomonads



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Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

These difficulties arose mainly from:

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The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

Dosage and Administration

In *women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral–250-mg.tablets/Vaginal–500-mg.inserts

SEARLE

Research in the Service of Medicine

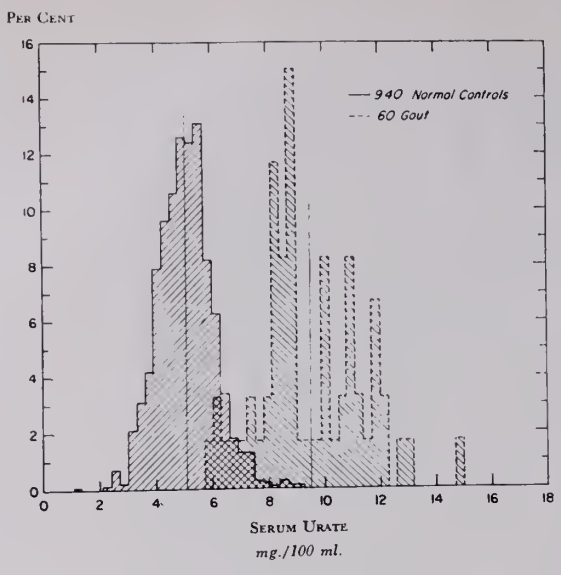


FIGURE 1.

was reported as 7.6 mg.%. He was treated with colchicine for the acute symptoms, and the pain subsequently subsided. Thereafter, he took probenecid daily. When he was seen in 1963 he had been asymptomatic for four years. A repeat X-ray showed calcium in the soft tissue of the left shoulder. The probenecid was stopped, and there have been no recurrences.

This patient was probably suffering initially from a non-specific bursitis of the shoulder.

The distribution for serum urate values of 940 non-gouty males and 60 gouty males is shown in Figure 1. Both groups contain a significant number of individuals with serum urate values that are in the same range. Therefore, it is clear that the separation of the two groups, gouty and non-gouty, cannot be made on the basis of serum urate values alone. With this overlapping in mind the value of 7.0 mg.% which represents two standard deviations above the mean, has been taken as the upper limit of normal for the enzymatic spectrophotometric procedure. Nevertheless, five per cent of normal males still showed urate values in excess of this upper limit and nine percent of gouty patients at times showed serum urate values below this concentration.[2]

Although gout represents approximately five percent of rheumatic problems, a recent study showed that 30 per cent of 737 rheumatic patients had hyperuricemia.[3] It was of interest in this group that 18 per cent of the patients with rheumatoid arthritis had hyperuricemia. Confusion between rheumatoid arthritis and gout is not an uncommon clinical problem. Obviously, the serum urate concentration should not be the deciding diagnostic factor.

One might ask about the reasons for an elevated uric acid in an individual who does not have renal disease or a blood dyscrasia. In some cases these individuals are relatives of gouty patients; in some cases the hyperuricemia has been produced by various drugs. Hyperuricemia occurs in approximately 20 per cent of the relatives of gouty individuals.[4] There might be a tendency to treat these hyperuricemic relatives with uricosurics. However, this is unreasonable considering the small percentage of these relatives that will eventually develop clinical gout (about 15 per cent will).[5] There is usually ample time to treat the hyperuricemia after the initial episode of acute gouty arthritis has occurred. The hyperuricemia may also be artificially induced by drugs. Hyperuricemia is frequently induced by small doses of salicylates which many patients with rheumatic complaints will use for pain. The thiazide diuretics, Vitamin B12, and pyrazinamide may do likewise.

I think that it is also worth mentioning that gout may not always be associated with a high uric acid, especially with the first attack. Also to be kept in mind is a newly described entity called "pseudogout" which may account for some of the cases of alleged gout with a normal serum urate concentration. "Pseudogout" or chondrocalcinosis is a syndrome which closely resembles the usual attack of gout.[6] However, in this condition crystals of calcium pyrophosphate rather than sodium urate are present in the synovial fluid and are thought to account for the inflammatory reaction. This acute arthritis will respond to colchicine. Another pitfall in the diagnosis of gout may be the use of the so-called therapeutic trial of colchicine. Although colchicine is generally specific for gout, the efficacy of colchicine does not necessarily indicate gout. The arthritis of sarcoidosis is said to subside with colchicine treatmest.[7] The spontaneous remission of other arthritides, such as episodic rheumatoid arthritis and traumatic arthritis, following a therapeutic test with colchicine may lead to an erroneous diagnosis.

The diagnosis of gout should be established in most cases by the clinical features of the disease. The demonstration of hyperuricemia

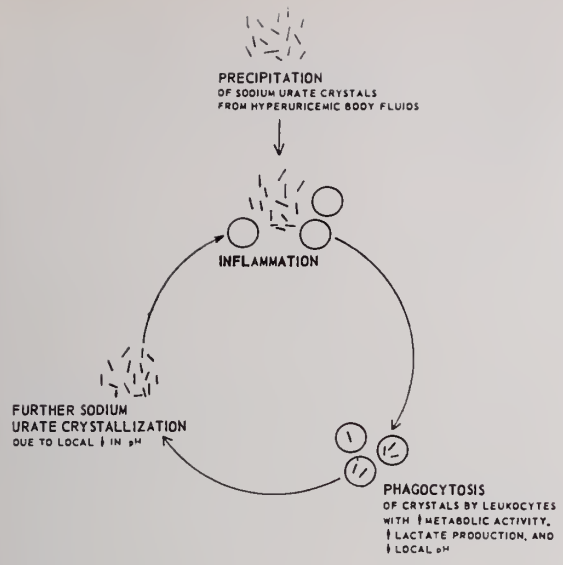


FIGURE 2

provides biochemical support to the diagnosis. However, the only absolute diagnostic test is the demonstration of urate crystals in the synovial fluid or in a tophus.

Producing Gout With New Drugs

A 42-year-old white male was found to have a blood pressure of 270/140 in March, 1962. The hypertensive workup was negative in regard to a specific etiology. He was treated with hydrochlorothiazide and guanethidine. In September, 1963, he developed acute pain, swelling, and redness of the first metatarsal phalangeal joint. The uric acid was 9.5 mg.%.

This history represents a rather classic case of thiazide gout. Hyperuricemia was noted with the use of thiazide diuretics in 1959, and by the following year there were case reports of acute gouty arthritis in patients taking these drugs.[7] Family history is negative for gout.

It is now believed that 90 per cent of blood uric acid is filtered at the glomerulus; most of this filtered uric acid is absorbed in the proximal tubule. Uric acid is then secreted in the distal tubule.[1] Thiazide diuretics in the low doses ordinarily used block secretion of uric acid much like low doses of aspirin. The result is hyperuricemia. The attack of "thiazide gout" that may result from this is identical clinically with an attack of primary gout.

The importance of hyperuricemia in the production of acute gout has been borne out by recent studies.[2] For many years it was thought that uric acid was not involved in the pathogenesis of the acute episodes of joint pain; recent investigations would certainly tend to indicate that it is. Although amorphous sodium urate will not provoke an attack of gout when injected into a joint, it has now been shown that suspensions of microcrystalline urate are capable of producing an inflammatory response when injected intra-articularly into both gouty and non-gouty individuals. For the typical acute attack of gouty arthritis to develop the following three conditions must prevail:

1. Crystals of monosodium urate must be present in the joint tissue.

2. An inflammatory reaction to the crystals must develop.

3. The inflammatory reaction must be propagated by the addition of more urate crystals to the area of inflammation.

During acute attacks of spontaneous gouty arthritis as well as in patients with an inflammatory reaction produced by the intra-articular injection of urate crystals, there is a marked increase in phagocytosis of urate crystals by leukocytes. Inflammatory leukocytes produce lactic acid; during phagocytosis an increased amount of lactic acid is produced. The lactic acid lowers the pH and results in the precipitation of more uric acid. Thus, the reaction tends to be self perpetuating as shown in Figure 2. Colchicine apparently inhibits the phagocytosis of sodium urate crystals by leukocytes in the synovial fluid. Consequently, lactic acid production is diminished, and the cycle is interrupted. Phenylbutazone and cortisone-like steroids would be beneficial because of their anti-inflammatory effect. An attack of gout may also be precipitated by initial therapy with uricosuric drugs, presumably by similar mechanisms.

Producing Gout by Diet

A 42-year-old white male was seen for a general examination in September, 1963. His weight was 242 pounds; a low calorie diet was prescribed. In November, 1963, he noted acute pain, redness, and swelling of the first right metatarsophalangeal joint. His uric acid was 10.2 mg.%.

For years it has been well recognized that weight reduction diets and high fat diets would produce acute gouty arthritis. One of

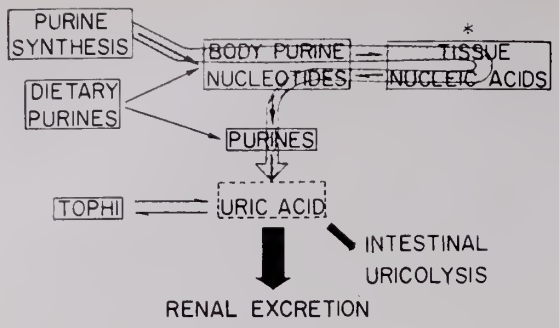


FIGURE 3.

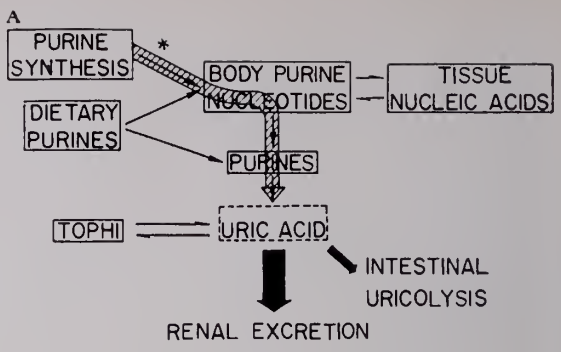


FIGURE 4.

the complications of the so-called starvation diet has been the development of acute gout. All of these diets produce a lactacidemia. This elevation of blood lactic acid in addition to decreasing the pH produces hyperuricemia by renal retention of urate. An increase in serum urate concentration ranging from 9 to 20 mg.% has been observed in non-gouty obese patients as a result of starvation.[2] The hyperuricemia and the hyperlactacidemia thus provide the necessary ingredients for the acute attack in the susceptible patient. The cause of the susceptibility is at present unknown. Similar conditions may produce an attack of acute gout in a postoperative patient who has not been on adequate preoperative prophylactic treatment with colchicine. The common denominator appears to be impaired carbohydrate metabolism. This may also account for the appearance of gout in pediatric patients, particularly those who have lactic-acidemia secondary to glycogen storage disease.[5]

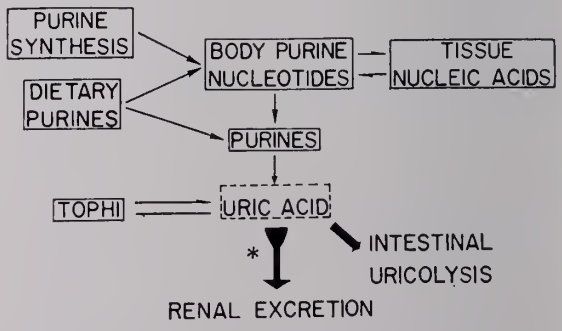
Producing Gout After Hematologic Procedures

A 57-year-old white male was diagnosed as myeloid metaplasia with myelofibrosis in March, 1962. X-ray therapy to his large painful spleen was begun in June, 1962. During the first week of therapy he developed redness, heat, and swelling of the left ankle, responsive to colchicine. The uric acid was 13.2 mg.%.

There is a 5 per cent incidence of gout in patients with polycythemia vera, myeloid metaplasia, and chronic myeloid leukemia. Gout associated with diseases of the hematopoietic system accounts for 10 per cent of all clinical cases of gout.[4] Acute gout may be precipitated by phlebotomy, P^{32} treatment, X-ray treatment, nitrogen mustard, or other chemotherapeutic agents. This has been attributed to an acceleration in the degradation of nucleic acids with subsequent increase in serum uric acid. Gout in association with these diseases has been termed secondary gout.

The mechanism of the production of hyperuricemia differs.[2] The hyperuricemia of secondary gout appears to be the result of an over production of nucleic acids as shown in Figure 3. Primary gout may be produced by an over production of uric acid presumably by a shunt mechanism using the known precursors glycine, formate, carbon dioxide, glutamate, and aspartic acid (Figure 4). Decreased renal excretion of uric acid may also be a cause of primary gout (Figure 5). In some patients both mechanisms may be in operation.

The difference between primary gout due to over production and secondary gout can be demonstrated by the pattern by which isotope labeled glycine appears in urinary uric acid. In primary gout the isotope appears in the urinary uric acid within a few hours after administration and in greater amounts than a normal control. By contrast a smaller proportion of the isotope from glycine appears in the urinary uric acid in patients with secondary gout during the first two days. During subsequent days, however, there is a progressive increase in the concentration of the isotope.



*Proposed site of the defect leading to hyperuricemia.

FIGURE 5.

These findings are interpreted as suggesting most of the newly synthesized purines were first incorporated into nucleic uric acid and then subsequently released for degradation to uric acid by the nucleic acid turnover.

Summary

Primary gout although an inherited disease of urate metabolism may have different etiologies, that is, over-production of urate, decreased excretion of urate, or both. Secondary gout is most commonly associated with blood dyscrasias. Iatrogenic gout may be produced by various drugs, diets, and other therapeutic procedures. The clinical symptoms, nonetheless, are similar and distinctive in all cases.

An erroneous diagnosis of gout may be made in various rheumatic conditions if too much emphasis is placed on an elevated serum uric acid or a therapeutic trial of colchicine. About 5 per cent of normal males will have an elevated uric acid. The uric acid may be elevated in relatives of gouty individuals or falsely elevated by various drugs. Therefore, the diagnosis of gout should be based mainly on the clinical features.

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General Anesthesia for Bronchography†

LEWIS FRANCIS, M.D.

Lexington, Ky.

Anesthesia for bronchography is at times difficult for both patient and surgeon. A method is described which permits safe, pleasant and effective general anesthesia for bronchography.

ANESTHESIA for bronchography has been difficult to manage. These difficulties may group themselves into: (1) Those due to the patient's physiological or psychological make-up; (2) The problems inherent in the technique of anesthesia management; (3) The immediate postanesthesia period.

The first group includes the cardiopulmonary cripple, the hyper-excitable personality, the patient with specific drug sensitivity, the patient with excessive pulmonary drainage, the young or old, poorly cooperative person and those having a fear of any procedure which involves the airway. The problems of this group will be considered as we discuss the second grouping.

The second group, that is, those problems inherent in anesthesia management, is obviously troublesome as evidenced by the diversity of methods of management of anesthesia for bronchography.

Technical Problems

Local anesthesia following heavy premedication, whether by topical or transtracheal instillation of the anesthetic agent, at times results in the patient who is too lethargic to maintain adequate gas exchange during or following the examination or to cough vigorously postoperatively. There is always the real danger of "caine" drug sensitivity, which has resulted in a number of fatalities in years past. The patient may not be able to cooperate sufficiently to permit good x-ray pictures. The apprehensive patients describe the procedure as "simply horrible".

General anesthesia has ranged from open drop induction and insufflation of anesthetic vapor through the bronchoscope side arm to pentothal induction followed by curarization. Pulmonary exchange has been maintained by means of chest cuirass, by intermittent closure of the bronchoscope or endotracheal tube while the dye is being instilled during x-ray exposure, or at times prayers for adequate exchange are uttered while a catheter is slipped through the trachea and dye is instilled while the patient is recovering from anesthesia.

Open drop induction is time consuming, unpleasant and frequently is accompanied by varying degrees of hypoxia regardless of the choice of the inducing agent. Following induction the patients frequently awaken too soon. The dye may be so viscid as to produce airway obstruction in spite of vigorous patient effort. With open drop induction, plus insufflation maintenance, positive pressure breathing during x-ray exposure is difficult or impossible. The patient with cardiopulmonary limitation is in jeopardy during the period of diminished exchange. The apprehensive patient greatly dislikes open drop induction. During this anesthesia management, x-rays are frequently blurred because of the excessive chest motion and until the patient coughs up the dye, his pulmonary gas exchange is limited. Semicurarization or chest cuirass artificial respiration following intravenous drug induction is also likely to be accompanied by inadequate gas exchange and excessive chest motion.

Over the past few years we have administered general anesthesia to seven hundred patients for endoscopic procedures. Of these, one hundred and sixty-one have had bronchography. Our patients have ranged in age from six to eighty years. We have found that the following method of anesthesia provides freedom from emotional upset, provides excellent gas exchange, good control of secretions and virtually complete elimination of dye from the pulmonary tree after x-ray exposures are made.

†*Presented at the September 21 meeting of the Kentucky Society of Anesthesiologists during the 1965 KMA Annual Meeting in Louisville.*

Author's Method

Adults are premedicated with a barbiturate "calming" dose plus atropine or scopolamine sufficient to depress secretion. The average dose is 100 mgm. of secobarbital or pentobarbital ninety minutes before examination, and atropine or scopolamine 0.45 mgm sixty minutes before examination. Promethazine is at times ordered one and one-half hours preop. The patient is taken to x-ray where induction with pentothal sodium plus succinylcholine is accomplished. The patient is then intubated with a small, long uncuffed endotracheal tube of sufficient size to permit controlled respiratory exchange, while the bronchoscopist inserts the bronchoscope along the endotracheal tube, performs his examination then suctions the bronchio-pulmonary airway, carefully removing all secretions possible. This step is vital to good x-ray visualization. (The ventilating bronchoscope is very convenient for this step in the procedure.) Following this rapid examination and tracheal toilet, the tracheal tube is removed and a cuffed endotracheal tube is inserted. To this is attached a right angle Rovenstine-Woods adapter. The patient's respiration is now under complete control of the anesthesiologist. Anesthesia may be continued with any agent of choice while relaxation is produced by succinylcholine. Through the nipple of the adapter a catheter of appropriate size is threaded down either right and left main stem bronchi and the dye is instilled. The control of any leak between catheter and fitting is easily done by the anesthesiologist's finger surrounding the junction of the catheter and nipple. During x-ray visualization the anesthesiologist may look into the mirror of the image intensifying fluoroscope and apply enough pressure on the rebreathing bag to fill the alveolar sacs to the desired degree of fullness. This avoids "flooding" and poor x-ray pictures. The chest remains quiet because the patient has been curarized and x-ray visualization is usually excellent. Following the x-ray exposures the patient is permitted to regain muscle tone while the x-rays are being processed. If the views are satisfactory the inhalation agent is blown off and the endotracheal tube is left in place. The patient's airway is then suctioned carefully with a whistle tipped catheter during which the patient must cough vigorously in order to remove the greatest part of the contrast dye. The patient is left on the x-ray table until he does cough vigorously. We have found that this technique results in removal of about ninety percent of the contrast dye from the tracheobronchial tree. This technique avoids the problem of operative and postoperative hypoxia, which is a common accompaniment of other forms of management of this procedure. The postoperative hypoxia usually results from inability of the patient to cough up the contrast dye (we use Dionosil becuse of its excellent contrast and freedom from drug reactions).

The child too young to permit easy venipuncture is induced with cyclopropane followed by venipuncture after the child is asleep, then anesthesia is continued as described above.

The complications in group three, or those of the immediate postoperative period, are due to drug reactions, hypoxia or hypercarbia from mechanical blockage of the tracheobronchial tree by the contrast medium or excessive respiratory depression accompanying the anesthesia. The technique described above obviates these problems.

We have had no deaths or complications. We have had an occasional patient who required transfer to the recovery room with the endotracheal tube in place because we believed the patient needed continuous vigorous aspiration of dye before the endotracheal tube was removed.

Summary

A method of general anesthesia for bronchography has been presented which has the following characteristics: It permits excellent respiratory exchange during the examination, it does not disturb the emotionally labile patient, it provides conditions permitting excellent roentgenograms, it permits prompt and virtually complete removal of the contrast medium from the tracheobronchial tree and it has not been accompanied by complications.

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Chronic Subdural Hematoma

S. Taha Anvari, M.D.*

THE diagnosis of chronic subdural hematoma can be a very difficult one. Frequently, this disease manifests itself by symptoms and signs which are not unlike those seen in cerebral vascular occlusive diseases, tumors or organic psychoses. Occasionally, headache, with or without mild memory loss and/or personality changes, may be the only presenting symptom. A high index of suspicion is important for the early diagnosis and definitive treatment of chronic subdural hematoma.

Echlin et al[1] classify subdural hematomas into acute, subacute and chronic. The acute include those cases which have been diagnosed within seven days following injury; the subacute from 8 to 22 days and the chronic over 23 days.

In many instances of chronic subdural hematomas no definite history of trauma can be elicited. In approximately 40 per cent of our cases at the Louisville General Hospital there was no history of head injury.

The examination of the cerebro-spinal fluid in chronic subdural hematoma may frequently be of no help since the pressure is usually normal and there may be no cells. The total protein content may be within normal limits or at most slightly elevated.

Roentgenograms of the skull rarely show fractures. If the pineal gland is calcified and can be seen on the anteroposterior view a shift to one side or the other will indicate the presence of a lateralizing lesion. But it should be remembered that the gland is calcified in only approximately 60 per cent of individuals over the age of 16 years. Furthermore, other causes of shift need to be considered, e.g., a hemispheric infarction and edema secondary to a vascular occlusive disease or even a tumor.

The electroencephalogram can offer a clue. Invariably there is noted a decrease in amplitude and/or a slow wave focus on the side of the pathology. However, these findings only lateralize the lesion which may be due to a contusion or laceration. But, if the hemiparesis should be on the same side as the clot (ipsilateral hemiparesis due to compression of the opposite cerebral peduncle) the possibility of a hematoma being present approximates 100 per cent. Such a picture, that is, a decrease in amplitude and/or slow wave focus on the same side as the hemiparesis is strongly suggestive of the possibility of subdural hematoma.

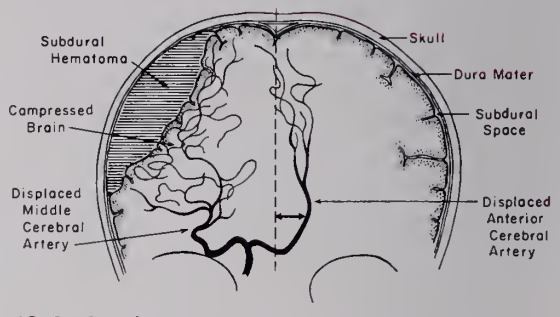


FIGURE 1. Schematic representation of subdural hematoma.

Recently, brain scanning techniques have been shown to be helpful.

Short of burr hole exploration the most definitive diagnostic procedure would be that of arteriography. The occurrence of an avascular area between the surface of the brain and the calvarium is practically pathognomonic of a subdural collection of fluid or membrane (Figures 1 and 2).

The following case is an example of a chronic subdural hematoma which was seen at Louisville General Hospital.

Case Report

A 54 year old male was admitted on May 4, 1963 in a poor state of awareness.

Present Illness: On admission he was not responsive to verbal stimuli. An inadequate history was obtained from various sources, including his daughter.

Until early January 1963 he had been considered to be in good health. On this latter date he began to use a cane because he was dragging his left leg. Apparently this started insidiously and became slowly but progressively worse. In spite of this he was able to get around, take care of his own needs and otherwise seemed to be as active and healthy as previously. About April 16, 1963 he had a sudden onset of weakness of both left extremities so that he was unable to walk or to use his left arm. It was also noted that the left side of his face sagged.

*From the division of neurology, department of medicine, University of Louisville School of medicine and Louisville General Hospital, Louisville, Kentucky.

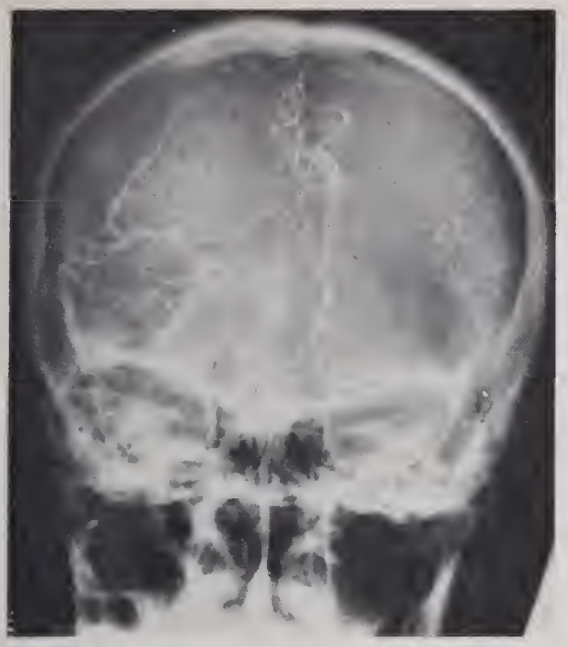


FIGURE 2. Antero-posterior view of a right carotid arteriogram shows a marked shift of anterior cerebral arteries from right to left. There is a large avascular area on the right side near the inner table of the skull which is compatible with subdural hematoma. Some branches of the left middle cerebral artery are also filled.

He was cared for at home and gradually regained some movement of his left leg. He was seen in the emergency room on April 26. At this time it was estimated that he had 90 per cent weakness of the left lower face and both left extremities. He was kept in the emergency room overnight on April 27 was sent to a nursing home. The personnel at this home stated that from the time of his arrival on April 27 and until his return to the hospital on May 4 he lay quietly in bed and would not move his left extremities. He had to be fed. He was incontinent of urine. If left alone he would sleep most of the time. On May 3 he developed fever, became poorly responsive and refused fluids. He remained in this condition until his admission on May 4.

Past History and System Review: His history indicated that in 1957 he had sudden onset of a right hemiparesis from which he made a good recovery. There were no details available about this episode. There was no history of any injury.

Physical Examination: He was a poorly nourished, dehydrated but well developed male who responded to painful stimuli by moving his right extremities or grimacing. Temperature was 104° (R). Respirations were 30 and pulse was 120 per minute and regular. The blood pressure was 160/80. There was no evidence of any lymphadenopathy. The heart was not enlarged to percussion and the sounds were normal. A2 was greater than P2. Examination of the chest showed some dullness in the region of the right lower lobe with rales. The abdomen was soft and flat. No masses or organs could be felt. There was no tenderness or rigidity.

The neurological examination was limited due to the poor level of awareness of the patient. His head was turned to the right and he resisted attempts to move it to the left. The fundi were not visualized because of occluding cataracts. The pupils measured 3 mm, were round, equal and regular, reacted briskly to flashlight and through a good range. The corneal reflexes were equal and active bilaterally. He responded to pin prick on his face by grimacing at which time a left lower facial weakness was noted. He wrinkled both sides of his brow equally well. He apparently did hear and occasionally would indicate this by mumbling in response to verbal stimuli. The uvula elevated in the midline. The gag reflex was equal and active bilaterally. The neck was not stiff.

Examination of the motor system revealed that there were no movements of the left upper extremity even to painful stimuli. The degree of weakness on the left lower was estimated at about 90 per cent. Resistance to passive manipulations of the left extremities was slightly increased. The stretch reflexes of the upper limbs were hyperactive but equally so. Those in the lower could not be obtained. To plantar stimulation there was an extensor response on the left side. There was a suck and snout reflex. Except for response to painful stimuli other forms of sensation could not be tested.

Laboratory Findings: On admission the urine showed evidence of albumin but a negative reaction for sugar and acetone. There were 12 to 18 red cells per high power field. The blood hemoglobin was 15.4 grams. There were 19,000 WBC per cu. mm. of which 88 per cent were polys and 12 per cent were lymphocytes. The hematocrit was 48 volumes per cent and the sedimentation rate 13 mm. The blood sugar taken on May 5, 1963 was 110 mgm. per cent. On this day the urea nitrogen was 54 and on May 8 it was 39 mgm. per cent. The serum chlorides on May 5 were 93 mEq and the C02 content was 24 mEq per liter. Serum sodium on May 8 was 140 and the potassium was 5 mEq per liter. Urine culture on the same day showed aerobacter cloacae. Three blood cultures taken on May 4 were all negative.

On May 4, 1963 the initial pressure of the cerebro-spinal fluid was 110 mm. of CSF. Removal of 6 cc of clear, colorless fluid reduced the pressure to 66 mm. of CSF. It contained 1 lymphocyte per cu. mm. and there was a trace of globulin. The total protein was 40 mgm. per cent. The blood and spinal fluid VDRL were both non-reactive.

X-ray of the chest made on May 4, 1963 showed an infiltration in the right lower lobe compatible with penumonia. Roentgenograms of the skull were normal but the pineal gland was not visualized. EKG made on May 5 showed changes suggestive of myocardial ischemia.

Initial therapy consisted of intravenous fluids and antibiotics in the form of penicillin and chloromycetin. He gradually improved and by May 15, 1963 he was awake and appeared aware of his surroundings. He said only a few words and was confused as to time, place and person. At times he did not recognize his daughter. The left hemiparesis remained unchanged. There was no visual field defect to con-

frontation. He refused to eat and had to be fed by a naso-gastric tube.

Discussion

In summary, we are presented with a 54 year old male with an inadequate history, who had a progressive left hemiparesis. At the time of admission he had a pneumonia which was treated and apparently cleared completely within 11 days.

The occurrence of a progressive weakness of the lower extremity followed by a relatively sudden left hemiparesis suggests several possibilities as to the nature and localization of this patient's illness.

In the first place it is not uncommon for some patients who are poor observers to only complain of weakness of the lower extremity without noting any symptoms referable to the upper on the same side. This is especially true if this be the non-dominant hand and even though the latter is significantly involved. The patient's attention may be directed to weakness of the lower much earlier than the upper extremity.

Initially, at least, most strokes involve the upper more than the lower extremity. This is due to the fact that many vascular lesions occur along the course of the middle cerebral artery and hence the usual hemiparesis is characterized by greater weakness in the upper limb. For the most part the cortical representation of the lower limb area is supplied by the anterior cerebral artery. Hence, it is a truism, that if there is a reversal of the weakness, i.e. greater weakness in the lower extremity the possibility of a carotid artery insufficiency is suggested.

Assuming that the patient had only weakness of his left lower extremity for a few weeks before developing a left hemiparesis, one would be dealing with a selective hemiparesis and this would strongly suggest a lesion in the surface of the brain in the parasagittal area.

In summary, from the anatomical standpoint the lesion was initially placed in the region of the leg area which is the parasagittal region of the posterior frontal cortex, with subsequent extension either deep or along the cortex to involve the arm and the face areas.

Differential Diagnosis: There are many possibilities which could be considered in this case but only a few of the more important ones will be mentioned.

1. Neoplasm. Since, historically, the lesion appeared to be a superficial one on the cortex, the absence of increased pressure and elevated protein in the cerebro-spinal fluid would be against the possibility of such diagnosis. A tumor located deep in the hemisphere should produce more symptoms and signs, e.g., visual field defects and sensory disturbances.

2. Occlusive lesion. As noted above, because of the initial symptom of weakness of the left lower extremity the possibility of an occlusive lesion in the right carotid artery in the neck was considered strongly. Approximately 35 per cent of occlusive lesions are located in the extracranial portion of the carotid vessels including the terminal portion of the common carotid or the proximal portion of the internal carotid artery. Hence, atherosclerotic process involving these areas was the initial impression.

3. Chronic subdural hematoma. Probably a good policy in dealing with individuals who have a syndrome of "stroke" is to maintain a high index of suspicion for possibility of trauma. We have a rule in our institution which says "given an individual who is poorly responsive and from whom a first hand history cannot be obtained and who particularly shows focal neurological signs, the possibility of a subdural hematoma needs always to be ruled out".

Hospital Course

On May 17, 1963 right common carotid arteriograms were made (Figure 2). These revealed a large avascular area on the right side between the surface of the brain and the inner table of the skull with a marked shift of the anterior cerebral arteries from right to left. The following day he was taken to the operating room and a large, old blood clot with membranes was removed from the right side. The patient tolerated the procedure well. Improvement was gradual but steady. He was discharged from the hospital on July 4, 1963 at which time he was able to walk without help and had only a minimal left hemiparesis. He was still somewhat confused. He was last seen in the clinic on January 17, 1964 at which time he was asymptomatic.

Conclusion

A case of a chronic subdural hematoma is presented. This picture may be confused, as it was in this case, with cerebral vascular occlusive disease. It is stressed that a high index of suspicion of this possibility should be maintained particularly when there is little or no reliable historical information available.

Reference

1. Echlin, F. A., Sordillo, S. V. R., and Garvey, T. Q.: Acute, Subacute and Chronic Subdural Hematoma, *J.A.M.A., 161,* 1345-1350 (Aug. 4) 1956.

SPECIAL ARTICLES

Medicine's Finest Hour†

DELMAS M. CLARDY, M.D.
Hopkinsville, Ky.

FRIENDS, Colleagues and Distinguished Guests—this particular moment climaxes for me a 30 year career in the practice of medicine and participation in its associated socio-economic problems. It is possible, and I would certainly hope, that I could accomplish more within the next twenty minutes than I have been able to accomplish in the combined 30 years. If I can clearly tell and convince you that there is a way to save the free enterprise of medicine, with its ethical ideals and moral codes, the very things that have made medicine great through the ages, I will have accomplished just exactly that. What I have to say will not be in any way telling you what to do. I will be merely stating how it can be done. With a clear understanding, I believe it would be your desire, and perhaps your determination, to defend the time-honored principles upon which we stand. It can be done ethically, legally and morally, and if you wish, as a sworn duty.

During this active period of 30 years, all the while socialization of medicine has been brewing, one cannot escape a certain amount of knowledge of what has happened. Certainly some definite ideas and conclusions should be had by those actively engaged. One big fault is, however, too few have been actively engaged. I am told by a responsible official of the AMA that only 5% of the nation's physicians have been active in dealing with the social, political and economic problems associated with the practice of medicine. I would suspect that a greater percent of Kentucky physicians have taken an active part, because this same official stated, "If all states had done as well as Kentucky, we would not be in trouble." I am convinced this is true.

Organized medicine has done a good job in delaying tactics, and probably has done all it can do, which has not been enough. The time has come to this critical moment, and to the inescapable fact, that if medicine is to remain a free enterprise, each individual physician must keep it so. We can no longer "Let George Do It" alone. Each one of us must understand what is at stake, face the fact, realize our responsibility and do our duty without hesitation.

We have heard much about our public image, in spite of all our accomplishments, including eradication of diseases, increased life expectancy, miracle drugs, miraculous surgery, along with 80,000 physician volunteers during World War II. The image of American medicine as portrayed to Congress by two leading Washington papers is that of a profession too timid and too divided to know its own mind and too blind to history even to be aware of what is happening to it. The American public sees us as a profession that will not fight for its own freedom nor for the freedom of its elderly patients. I believe we have permitted our image to be diminished by our failure to make our resentments known and to speak out the truth to counter the propaganda barrage of outright lies. No one has any respect for any person who is not willing to stand up and speak out for what he thinks is right. To be a traitor to his cause places him at the bottom. Confucius is credited with saying, "To know what is right and not do it is the worst of all cowardice." Judas betrayed Christ for 30 pieces of silver. Brutus stabbed

†President's Address delivered by out-going KMA President Clardy at the Annual Meeting of the Association on September 22, 1965.

his former friend, Julius Caesar, in the back. Judas and Brutus are not appreciated names when ones are so-called. A Norwegian named Quisling betrayed his country during World War II. A new word was added to the languages and to the dictionaries. The names of patriots have been and will be revered for all times, while the weaklings have always and will continue to perish in scorn. Signs of weakness, indecision and cowardice cannot, under any circumstance, improve our public image.

Another thing that we have been cautioned about is "Not to rock the boat." This has been good up until this time, but now our boat is sunk, and I think it would be much better to rescue the boat than it would be to pick up the pieces after it has been torn apart.

There are certain things we cannot do. In 1938 the District of Columbia Medical Society and the AMA were indicted by the Attorney General of the United States for violation of Section 3 of the Sherman Antitrust Act. This came about because a group of employees in the District of Columbia set up their own hospital and medical care program, using salaried physicians. The judicial councils of the D.C. Society and the AMA declared this to be unethical practices and the participating physicians were expelled from these organizations. This, in turn, deprived them of their hospital affiliations and the suit was entered, claiming that these physicians were restrained and deprived of their constitutional rights. Litigation continued until May 1941, when the Supreme Court declared the D.C. Society and the AMA guilty and each were fined $1,500 and $2,500 respectively. What I am trying to say is, that organized medicine cannot discipline its members for participating in health plans, which seem to us to be unethical. Labor unions can prevent their members and others from working, as they are exempt from the antitrust laws, but organized medicine is a profession and does not enjoy the same privileges or protection. So, resolutions by this association, that could be interpreted as being threatening, intimidating, or conspiring to restrain others would not be legal and might invite prosecution.

To strike or refuse to treat patients would be unthinkable, and contrary to all moral and traditional concepts of the high standards of medical practice. Labor unions can strike, tie up nationwide commerce and industries, demand and get all kinds of benefits, legislation and protection by the courts. This is not true of our profession. The public for some reason expects and demands a different kind of performance from their physicians. To strike would incite the wrath of everyone, including Congress and the Courts. Neither can organized medicine, nor the individual physician afford to join their enemies in imposing socialized medicine upon the people and destroying the profession.

We have observed carefully, so far, those things we cannot do, but the time has arrived for us to know exactly what we can do, and to take a positive approach. First, I think we must review the evils of socialized medicine and decide individually whether or not the statements of condemnation made over the many years by organized medicine, and by individuals are true. We should realize this is only a part of the plan to complete socialization and the eventual "Great Society." We should know the real objectives of the socialists, keeping in mind that communism is also socialism, and the ultimate aim is the destruction of the home and the church, and to reduce everything to the same level of mediocrity. Socialism does not propose to create anything. It takes over what has already been created, always under the pretense of benevolence and public good. It is always sponsored and promoted by those who call themselves "liberals," and always deny that they are socialists. It has destroyed medicine in other countries and it will destroy it here. We certainly know that the cost of medical care for the aged is not the cause of the economic ills of the country. We also know that taxation and inflation have robbed these people of their life savings, not the physician, nor the hospitals. Taxation and inflation will also rob you of your savings.

It is well to reflect upon some well-known philosophical truths at this time. If some things are morally wrong, legislation cannot make them right. A politician who sells his soul for a vote will also sell you for something else he wants. A person who would steal an election will steal anything and is an enemy to a free society.

Government does not and cannot create Great Societies. Only individuals can accom-

plish this. The only great societies in history have been free societies in which the individual had maximum rights and privileges and was the master, not the servant of government. Freedom does not perpetuate itself. Daniel Webster once said, "God grants liberty to those who love it and are ready to guard it and defend it." There is no freedom for the weak.

Public Law No. 89-97 is as wrong and as evil as HR 6675. Its approval by Congress and its signing by the President did not make it right. It is the product of its authors who are not the same as the names that appeared on the bill. It was written by more astute persons who are educated along socialistic lines, and without the advice or consent of organized medicine. It is the hole in the dike, and more legislative efforts are certain to follow soon. The politicians have used it and will continue to use it for the purpose of getting elected without regard to the consequences.

The labor unions have demanded it to save their own funds to further their own political aims, and this was the price of the last presidential election. Some congressmen do not hesitate to tell you, "Doctor, I know you were right, but I was committed to vote against you." Another congressman said, "The medical profession has been sold to labor and there is nothing you can do to change Medicare." When asked why Congress wouldn't go along with "Eldercare," he answered, "Just one reason. Management would have to pay half of "Medicare." When asked about the cost, beds and deterioration of medical care, as has happened in European countries and Britain in particular, he stated, "They don't care."

So, you see, most of the politicians don't care. If medicine is to be saved, we, as individual physicians, will have to do it, because we are really the only ones who do care. Here is how we can do it, morally, ethically and legally, at the same time improve our public image, maintain our self-respect and preserve the tradition and ethics that have made American medicine what it is today. Each of us can rededicate ourselves to the following: "I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing." I will charge a fee commensurate with my service and will expect payment from those who are financially able to pay. For those who are not financially able, I will donate my service as my contribution to the welfare of my fellowman, as has always been the tradition of our honorable profession. I will uphold the honor, the ethics and the dignity of my profession that has always been right. I shall forever strive to improve the care of my patients by the improvement of my own competence and through the many facets made possible by our country, state, national and world medical associations. "I will not dispose of my services under terms or conditions which tend to interfere with or impair the free and complete exercise of my medical judgment and skill, or tend to cause deterioration of the quality of medical care." "I cannot morally, ethically or professionally serve the best interest of my patients under any third party program that intrudes into the physician-patient relationship and interferes with medical judgment as to diagnosis and treatment." I will not cooperate with any destructive forces that would destroy those things which I hold to be sacred.

Abraham Lincoln stated my feeling in saying, "I am not bound to win, but I am bound to be true. I am not bound to succeed, but I am bound to live up to what light I have. I must stand with any body that stands right; stand with him while he is right and part with him when he goes wrong." He also gave us good advice when he said, "Let us have faith that right makes might, and in that faith let us dare to do our duty as we understand it."

These words from "My Creed" by Dean Alfonge were quoted to the senior students of the medical schools of the University of Louisville and University of Kentucky, and I think they would be equally appropriate here. "I do not choose to be a common man. It is my right to be uncommon. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk, to dream and to build, to fail and succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the stale calm of Utopia. I will not trade freedom for beneficence, nor my dignity for a handout."

If each individual physician would ponder

(Continued on Page 450)



In Retrospect

THE actions of the 1966 General Assembly at Frankfort are now a matter of record. Any appraisal of its accomplishments is generally regarded favorably. The measures enacted into law seem constructive and good for the progress of Kentucky and the administration will in all probability be credited with having exerted sound and enlighted leadership.

There were many measures proposed that pertained directly to the health of our people. The Board of Trustees looked forward in 1965 and made provision for interested physicians to carefully scrutinize proposed legislation and to make every reasonable effort to influence it favorably. This was effected through the key man system which seemed to work very effectively, due principally to the alert watchfulness of Doctor J. C. Cantrill and his committee. Physicians from more than 15 county medical societies visited Frankfort during the session offering such help and guidance as they were able to the legislators, and a great many more were faithful in contacting their senators or representatives personally or by telephone and letter informing them of medicine's attitude on issues with which they were not very familiar. Mr. Gilbert Armstrong proved to be very effective in his efforts to transmit medical opinion to the legislators. He was greatly assisted by Mr. Bob Cox who had previous experience in this capacity.

Compulsory phenylketonuria screening of all infants less than 28 days old in hospitals became law. This is a controversial measure. Its purpose is to detect potential mental retardation in infants before it becomes manifest. Dietary management thereafter constitutes the means of prevention. The principal question at issue was whether this test should be required on a compulsory basis or left to voluntary screening. The National Association for Retarded Children has urged its use very widely but experience over the entire country indicates that only an estimated 20% of newborns throughout the nation are now being screened for PKU.

It is thought that any such mandatory legislation should remain flexible and be governed by the standards adopted by the State Board of Health. There remains some disagreement about the value of this method of testing and also about the manner and effectiveness of treatment of infants where the test indicates a strong probability of mental retardation. It is certain that this screening is more widely used in the United States than in most other countries. If the testing is intelligently done and the results followed carefully according to our present knowledge, it will at least constitute a very large and perhaps helpful experiment since the vast majority of infants are born in hospitals.

The proposed Medical Examiner system to assist or replace our present coroner system failed to pass. While this must be regarded as constructive legislation there was some difference of opinion among physicians as to the advisability of passing the bill, perhaps due mostly to a lack of understanding. It will almost certainly be presented in clearer and perhaps more practical form to the next legislature.

Most physicians felt that the bill to extend the statue of limitations in personal injury cases from one to two years represented poor legislation and were glad that it failed to pass the Senate.

It seems abundantly clear that the KMA Council on Legislative Activities implementing their recommendations through the key man system is an effective and helpful instrument to influence proposed legislation which pertains to health. Since health is primarily our problem it would be well to keep and improve our communication with elected and would be legislators, not during the general assembly only but in the interims.

SAM A. OVERSTREET, M.D.

We Humbly Bow Our Heads

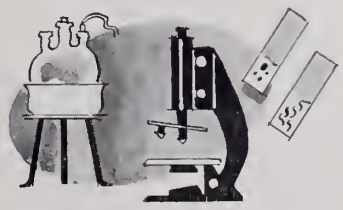
IN 1951 the Kentucky Medical Association made a great fuss about celebrating our 100th Anniversary. We are proud to have been in continuous organization now for 115 years and can rightfully claim considerable seniority over most of the state medical societies. There comes, however, a report from the Medical Society of New Jersey, "the oldest such society in the United States," which was founded on July 23, 1766 in New Brunswick, New Jersey at Mr. Duff's Tavern. Seventeen physicians signed the instrument of Association and elected the first president, Rev. Robert McKean, clergyman and physician who at that time was rector of an Episcopal Church.

In 1772 this Society initiated steps to regulate the practice of medicine in New Jersey, began the recording of vital statistics in 1820, encouraged the enactment of protective labor laws in 1851, fostered legislation to insure purer milk supply, to prevent air pollution and provide mosquito control, all before the turn of the century. As early as 1870 the Society insisted that race, color and creed were no barrier to membership. In 1866 they held their first centennial celebration in New Brunswick. Their bicentennial celebration is to be held at Atlantic City on May 14th through May 18th this year.

We bow our heads in veneration and respect to this, the oldest state medical society in America.

In June of 1966 the Medical Society of New Jersey will honor Doctor Harry A. Davidson who has been the editor of their Journal for 25 consecutive years. We, with his colleagues, wish to honor Doctor Davidson for his long, faithful and outstanding service to his profession and to his state Medical Society. Only one other man whom we have known has served so long as medical editor, and that is Doctor Walter E. Vest, who edited the West Virginia Medical Journal from 1937 until his death in 1962. Incidentally Doctor Davidson and Doctor Vest were very close personal friends. Their combined service to medicine in their respective areas cannot be measured. We greatly admire them and offer our congratulations to their respective societies.

SAM A. OVERSTREET, M.D.



ORGANIZATION SECTION

Color Television to be Feature At KMA 1966 Annual Meeting

Four-and-a-half hours of color television clinics, covering a wide range of medical topics, will be among the features of the 1966 KMA Annual Meeting in Louisville September 20-22, according to Everett H. Baker, M.D., Louisville, KMA president.

As chairman of the Council on Scientific Assembly, who planned this year's meeting, Doctor Baker recently released information on several of the sixteen prominent authorities who will participate in the program as the guests of cooperating specialty groups.

The scientific program, which will be held at the Convention Center at the corner of Sixth and Walnut Streets in Louisville, was prepared by the Scientific Program Committee, chaired by Roderick Macdonald, Jr., M.D., Louisville.

Appearing on the program on Tuesday, September 20, will be Thomas K. Oliver, Jr., M.D., Seattle, Wash., the guest of the Kentucky Chapter, American Academy of Pediatrics. His topic will be *"The Undergrown Infant and Neonatal Hypoglycemia"*. Doctor Oliver is professor of pediatrics at the University of Washington College of Medicine, and head of the division of neonatal biology.



Doctor Winter

Prior to his appointment on the faculty at the University of Washington in 1963, he was associated with the medical schools of Cornell University and Ohio State. He received his medical degree from Harvard in 1949. Doctor Oliver is a fellow of the American Academy of Pediatrics, and a member of several other pediatric organizations. His topic at the Tuesday meeting of his host specialty group has not been announced.

Chester C. Winter, M.D., professor of surgery and urology at Ohio State University School of Medicine, Columbus, will be the guest of the Kentucky Urological Association, and will speak to that group on Tuesday afternoon on *"Anti-Reflux Surgery."* His topic at the Tuesday morning general session will be *"Neonatal Kidney Function"*.

Doctor Winter, who was professor of surgery and acting head of the division of urology at UCLA before going to Ohio State in 1960, was graduated from the State University of Iowa School of Medicine in 1946. He was international editor for Nuclear Medicine in Excerpta Medica in 1964, and holds membership in the American Urological Association, the American College of Surgeons, Sigma Xi, and a number of other organizations.



Doctor Oliver



Doctor Saslow

The guest of the Kentucky Chapter of the American College of Physicians, Samuel Saslow, M.D., Columbus, Ohio, will speak at the Wednesday morning general session on *"A Practical Approach to Problems in Infectious Diseases"*. Doctor Saslow, who is professor of medicine and chief of the division of infectious diseases at Ohio State University College of Medicine, will address his host group on Tuesday afternoon. His topic will be *"A Practical Approach to the Systemic Fungus Infections"*.

He received his A.B. degree from Transylvania College in 1937; an M.S. from the University of Kentucky in 1939; his Ph.D. in 1942 and M.D. in 1946, both from Ohio State. He is a fellow of the American College of Physicians, a member of Sigma Xi, the Society for Experimental Biology and Medicine, and many others.

Additional information on speakers and program details will be released by Doctor Baker as this material becomes available.

Preliminary Program Released For 1966 Annual Meeting

The preliminary outline of the program for the 1966 KMA Annual Meeting, to be held September 20-22 at the Convention Center in Louisville, has been released by Everett H. Baker, M.D., KMA president and chairman of the Council on Scientific Assembly.

The full scientific program, with information on guest speakers, will be published in later issues of The Journal. A tentative basic program follows:

Tuesday, September 20

Morning Session

Theme: *"Recent Advances in Fetal and Neonatal Problems"*

Chester C. Winter, M.D., Columbus, Ohio — *"Neonatal Kidney Function"*

Willis Brown, M.D., Little Rock, Ark. — *"Premature Rupture of the Membranes"*

Thomas K. Oliver, M.D., Seattle, Wash. — *"The Undergrown Infant and Neonatal Hypoglycemia"*

Color TV Clinic — Billy F. Andrews, M.D., Louisville, Moderator — John G. Gorman, M.D., New York, N.Y., panelist; Others to be selected.

Afternoon Session

Eight of the 16 participating specialty groups will hold their scientific sessions on Tuesday afternoon. There will be no general session at that time.

Wednesday, September 21

Morning Session

Theme: *"Treatment of Infections"*

Howard H. Steel, M.D., Philadelphia, Pa. — *"Hospital Acquired Infections"*

Samuel Saslow, M.D., Columbus, Ohio — *"A Practical Approach to Problems in Infectious Diseases"*

Color TV Clinic — Mohammad Atik, M.D., Louisville, Moderator — Panelists to be selected.

Afternoon Session

Theme: *"New Dimensions in Therapeutics"*

Color TV Clinic—E. D. Pellegrino, M.D., Lexington, Moderator — Panelists to be selected.

Norman Cameron, M.D., New Haven, Conn. — Topic to be announced.

Eugene C. Klatte, M.D., Nashville, Tenn. — Topic to be announced.

Thursday, September 22

Morning Session

Theme: *"Untoward Drug Reactions"*

Leon Goldman, M.D., Cincinnati, Ohio — *"Some Uncommon Drug Reactions"*

Robert W. Weber, M.D., Salina, Kan. — *"Antibiotic Complications"*

George E. Moore, M.D., Buffalo, N.Y. — *"Anticancer Agents"*

Color TV Clinic — Randolph Scheen, M.D., Louisville, Moderator — Panelists to be selected.

Afternoon Session

No general scientific session has been scheduled for Thursday afternoon. Eight specialty groups will meet at that time.

Fifteenth District to Meet

The annual meeting of the KMA Fifteenth Trustee District has been scheduled for June 1 at Middlesboro, according to E. C. Seeley, M.D., London, district trustee. Philip L. Fuson, M.D., Middlesboro, is in charge of local arrangements. No further details on this meeting were available as *The Journal* went to press.



AMA PRESIDENT James Z. Appel, M.D., Lancaster, Pa., warned against expanded Federal health programs during his address to the Kentucky Medical Association at the April 13 and 14 Interim Meeting at Cumberland Falls. Doctor Appel was one of a number of guest authorities appearing on the program, which drew an unusually large attendance.

New Attendance Records Set At KMA Interim Meeting

A total of 261 physicians, their wives, and guests set a new record for attendance at the Kentucky Medical Association Interim Meeting April 13 and 14 at Cumberland Falls, Everett H. Baker, M.D., Louisville, KMA president, announced.

A capacity crowd was on hand at the Wednesday evening dinner session, which was followed by a panel discussion on utilization review, covered from the viewpoints of organized medicine, the Federal government, hospitals, and prepayment plans.

At Thursday's luncheon session, AMA president James Z. Appel, M.D., outlined the AMA's role in formation of policies on behalf of the medical profession relative to the Medicare law (Public Law 89-97) and the Heart, Cancer and Stroke law (PL 89-239). Doctor Appel also warned against expanded new Federal health programs.

Physicians attending the meeting also heard talks on voluntary prepayment plans as viewed by labor, and the general and health objectives of the Appalachian Regional Commission.

The KMA Board of Trustees met on Tuesday evening and Wednesday, April 12 and 13, prior to the Interim Meeting. Also holding sessions were the Boards of Directors of the Kentucky Educational Medical Political Action Committee (KEMPAC) and the Woman's Auxiliary to KMA.

Other pictures taken during the Interim Meeting will be published in the June Journal.

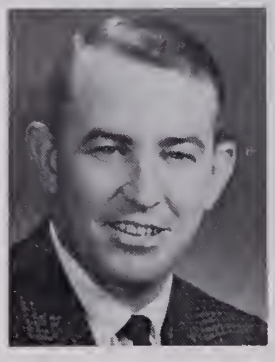
Blue Shield Extends Medicare

Kentucky Physicians' Mutual, the Blue Shield Plan for Kentucky, is among the 72 U.S. Blue Shield Plans and the Puerto Rico Plan now offering or planning to offer programs that will pay all or part of the deductible and co-insurance features of Part B of Medicare. There are 74 Plans in the United States.

The Insurance Page of the April issue of *The Journal* (page 284) explained details of the coverage to be offered by the Blue Shield Plan in Kentucky, which will extend, but not duplicate, Medicare benefits to subscribers 65 or older.

Dr. Barton Re-elected Chairman Of KEMPAC Board of Directors

The KMA Board of Trustees has named the Board of Directors of the Kentucky Educational Medical Political Action Committee for the coming year.



Doctor Barton

Harold B. Barton, M.D., Corbin, was re-elected Chairman of KEMPAC, Daryl C. Harvey, M.D., Glasgow, vice-chairman, and Richard F. Greathouse, M.D., Louisville, secretary-treasurer.

Other members appointed were: Jim Cox, M.D., Hopkinsville; Carl Cooper, M.D., Bedford; David B. Stevens, M.D., Lexington; Jerry D. Fraim, M.D., Paintsville; Hoyt D. Gardner, M.D., Louisville; W. Donald Janney, M.D., Covington; Joseph R. Miller, M.D., Benton; C. C. Rutledge, M.D., Hazard; Mrs. Raymond E. Jones and Mrs. James R. Barnes, M.D., both of Louisville, and Mrs. Arthur S. Holmes, Williamsburg.

Third Trustee District to Meet June 8 at Madisonville

KMA President Everett H. Baker, M.D. Louisville, will be the featured speaker at the Third KMA Trustee District meeting at the Madisonville Country Club Wednesday evening, June 8, according to an announcement by Gabe A. Payne, M.D., Hopkinsville, district trustee.

A brief presentation by a representative of KEMPAC is also planned for the meeting, which will begin with a social hour at 5:00 p.m. and dinner at 6:30. Individual Invitations will be sent to district members and their wives, Doctor Payne said.

In conjunction with the meeting, a seminar on "Gastrointestinal Diseases" will be presented that afternoon at the Rizpah Shrine Temple under the auspices of the University of Kentucky Medical Center. Faull S. Trover, M.D., Madisonville, is assisting with arrangements for the meeting. Arrangements have been made for the district members and their wives to play golf at the Madisonville Club.

AMA Annual Meeting June 26-30 Will Feature Best in Medicine

The most recent developments in medical research and techniques will be made available to the nation's physicians June 26-30, when the American Medical Association meets in Chicago for its 115th Annual Convention.

Important socio-economic problems facing the medical profession will also be discussed by the AMA's House of Delegates, meeting at the Palmer House, headquarters of the Convention. Leading the KMA delegation will be senior delegate J. Thomas Giannini, M.D., Louisville, accompanied by John C. Quertermous, M.D., Murray, and Charles C. Rutledge, M.D., Hazard, delegates.

Among the features of the scientific program, to be held at McCormick Place, will be six general sessions concerned with population expansion, emphysema, burns, mysterious fevers, community hospital and coronary care units, and headache.

Medical motion pictures and color television will be presented daily at the scientific sessions. Approximately 350 scientific exhibits have been scheduled.

Everett H. Baker, M.D., Louisville, KMA president, called this "the most important medical meeting of the year", and has urged all Kentucky physicians to make early reservations. (A form for this purpose appeared on page 280 of the April *Journal*). Wives are also encouraged to participate in the meeting of the AMA Auxiliary, to be held simultaneously at the Drake Hotel.

Sixth Trustee District Meeting To Feature Talk by Dr. Baker

Everett H. Baker, M.D., Louisville, president of KMA, will deliver the main address at the Sixth Trustee District's second meeting of the year at Bowling Green on Tuesday evening, June 14, according to Rex E. Hayes, M.D., Glasgow, district trustee.

Following Doctor Baker's talk will be a discussion of Sections XVIII and XIX of Public Law 89-97 (Medicare). Individual invitations to the meeting will be issued to member physicians and their wives, Doctor Hayes said. Another feature on the program will be a brief presentation on KEMPAC (the Kentucky Educational Medical Political Action Committee).

Paul J. Parks, M.D., Bowling Green, secretary for the Sixth District, is making arrangements for the meeting.

Dr. Quill to Head Ky. Surgeons; Dr. Grise is President-Elect

Laurence M. Quill, M.D., Newport, was installed as president of the Kentucky Chapter of the American College of Surgeons, and Richard F. Grise, M.D., Bowling Green, was chosen president-elect, at the April 7-9 meeting of the Chapter at Lexington.

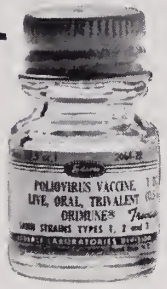


Doctor Quill

The new president succeeds Charles M. Edelen, M.D., Louisville, in office. David A. Hull, M.D., Lexington, remains as secretary-treasurer. New council members elected this year are: Walter I. Hume, Jr., M.D., Louisville; John Dickinson, M.D., Glasgow; and Ballard W. Cassady, M.D., Pikeville.

Approximately 80 physicians attended the meeting at the Imperial House and the University of Kentucky Medical Center.

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Only 2 doses required for complete, initial immunization for patients more than a year old. *Effectiveness*—may be expected to confer active immunity against all three types of poliovirus infection in at least ninety percent of susceptibles only if given at full dosage, as directed. No characteristic *side effects* have been reported. There are, however, certain *contraindications*. These are, broadly: acute illness, conditions which may adversely affect immune response, and advanced debilitated states. In these, vaccination should be postponed until after recovery.

In infants vaccination should not be commenced before the sixth week of life. Do not give to patients with viral disease, or if there is persistent diarrhea or vomiting. ORIMUNE and live virus measles vaccine should be given separately.

Dosage—initial immunization: two doses each given orally at least 8 weeks apart. (Give a third dose to infants at 10-12 months.) Booster immunization: one dose, given orally. See package literature for full directions.

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Twenty Physicians Listed As New KMA Members

Twenty Kentucky physicians have been recently added to the KMA membership roster, according to the membership department. Among those named were three Louisvillians: Walter A. Mitchell, M.D.; Todd G. Richardson, M.D., and John J. Wernert, Jr., M.D.

Also listed were two from Frankfort: Doyle D. Hagg, M.D., and O. M. Patrick, M.D.; and Harry Galloway, M.D., F. A. Martin, M.D., and William A. McLeod, M.D., all of Paris. Others were: Walter F. Beckett, M.D., Bowling Green; Dennis A. Brown, M.D., Florence; and William B. Cook, M.D., Prestonsburg.

Also included were: George Daaboul, M.D., Harlan; E. Kathie Elliot, M.D., Prospect; Samuel W. Gehring, II, M.D., Flemingsburg; Robert J. Long, M.D., Berea; Joseph L. Milburn, M.D., Madisonville; Luther W. Pearce, M.D., Anchorage; John A. Reeves, M.D., Covington; Robert O. Schoffstall, M.D., Whitesburg; and Richard T. C. Wan, M.D., Morgantown.

Industrial Medical Group Elects

John E. Eckerle, M.D., Louisville, was installed as president and Walter L. O'Nan, M.D., Henderson, was named president-elect of the Kentucky Industrial Medical Association, meeting March 27 in Louisville.

Other officers elected were: vice-president, William P. VonderHaar, M.D., Louisville; secretary-treasurer, Albert S. Irving, M.D., Louisville; and one member of the Board of Directors, Herman D. Pocock, M.D., Louisville. The meeting was held at the Brown Hotel in conjunction with the second Governor's Occupational Health Conference.

Ky. Dentists Name Dr. Lyddan President of KDA for 1967

Pat H. Lyddan, D.D.S., Louisville pedodontist, was named president-elect of the Kentucky Dental Association at the 106th annual session of KDA held in Louisville April 5-8. Thomas J. Boldrick, D.D.S., Owensboro, was installed as president.



Doctor Lyddan

In other action taken during the meeting, the Association's House of Delegates passed a resolution asking the Kentucky State Board of Health to require fluoridation of water in the state's first- through fourth-class cities. The House also approved a building committee recommendation to buy a $150,000 building for the new headquarters office in Louisville.

William K. Keller, M.D., professor and chairman of the department of psychiatry at the University of Louisville School of Medicine, was the KMA exchange speaker at the meeting, held at the Brown Hotel.

Doctor Lyddan, an instructor of pedodontics at the University of Louisville School of Dentistry, is a graduate of Indiana University School of Dentistry and did postgraduate work at I.U. and in Boston. He is a fellow of the American College of Dentists and the Academy International of Dentistry.

KMA Senior Day Programs Held At U. of L. and U. of K.

Medical school seniors at the University of Louisville and the University of Kentucky were the guests of honor at Senior Day programs presented by KMA on March 21 and April 12, respectively.

The two programs, presented annually by the Association in cooperation with the medical schools and the Jefferson and Fayette County Medical Societies, were held at the Executive Inn in Louisville for U. of L. seniors, and at the Imperial House in Lexington for seniors at U. of K.

Donovan F. Ward, M.D., Dubuque, Iowa, immediate past president of the American Medical Association, was the principal speaker at the University of Kentucky program, sharing the spotlight with Everett H. Baker, M.D., Louisville, KMA president, and other representatives of KMA and the Fayette County Medical Society.

C. V. Edwardson, Louisville, a first vice-president of the Lincoln Income Life Insurance Company, addressed University of Louisville seniors, substituting for the scheduled speaker, who was prevented from attending by bad weather. Both Senior Days ended with a dinner, at which individual members of the county societies acted as hosts to individual class members.

Both programs were arranged by the KMA Senior Day Committee, chaired by Fred C. Rainey, M.D., Elizabethtown. This was the Twelfth Annual Senior Day at the University of Louisville and the Third at the University of Kentucky.

Lancaster Seminar Program Planned June 16 by KAGP

The Lancaster Regional Seminar of the Kentucky Academy of General Practice has been planned for Thursday afternoon, June 16 at the new Garrard County High School Auditorium, according to Paul J. Sides, M.D., Lancaster, program chairman.

A talk on "The Future of Private Practice" by Clayton L. Scroggins, Cincinnati, of Clayton L. Scroggins Associates, professional business management firm, will be featured at the dinner that evening.

The scientific session, for which registration will begin at 12:45 p.m., will include papers by Carl Friesen, M.D., E. D. Pellegrino, M.D., and Edward Ray, Sr., M.D., all of Lexington, and Billy F. Andrews, M.D. and Edward E. Landis, M.D., of Louisville. A social hour beginning at 5:30 will be held before dinner, which starts at 6:30.

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TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725'	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
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The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

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Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

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TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. References: 1. Isenberg, Henry D.: Health Laboratory Science 2:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine 70:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science 1:185-256 (July-Aug.) 1964.

Ky. Public Health Assn. Names Miss Goodman President-Elect

The Kentucky Public Health Association, meeting April 5-7 in Louisville, chose Miss Frances Goodman, director of nursing at the Commission for Handicapped Children in Louisville, as its president-elect.



Miss Goodman

Miss Goodman, who will succeed Mildred Gabbard, M.D., Booneville, in office next April, has worked with the Commission for 20 years. She is a former supervisor of nursing at Kosair Crippled Children's Hospital in Louisville, and served with the Army Nurse Corps in World War II.

In other action taken during the meeting, the Association gave its annual group award to the Pike County Medical Society Auxiliary for its activities in diabetes testing and in the field of mental health.

U. of L. Medical-Dental Center Gets $2.7 Million U.S. Grant

A $2.7 million Federal grant for use in constructing the research facilities for the new University of Louisville Medical-Dental complex was announced April 7 by Dean Donn L. Smith, M.D., of the medical school.

Doctor Smith said the bulk of the grant will be used for building and equipping a 14-story research tower for the medical school. He said also that the university also expects approval of two additional applications for funds totaling $9.3 million in U.S. funds for the medical-dental center.

The $12 million total in Federal grants will be matched by $6 million from a city bond issue and $3 million from a state bond issue, both passed last fall. Work on the center is expected to begin soon.

KMA Diabetes Detection Program Effective in Alerting Public

"The KMA Diabetes Detection Program continues to be an effective means of alerting citizens to the dangers of undetected and uncontrolled diabetes, and to persude them to be tested!" Irving F. Kanner, M.D., Lexington, chairman of the KMA Diabetes Committee, said recently.

The 15th Annual Drive, sponsored by the KMA in cooperation with the American Diabetes Association, saw 66,501 free tests made and 252 proved cases reported.

More than 2,300 previously unknown diabetics have been found since the first KMA drive in 1951. The Kentucky Medical Association started the first Diabetes Detection and Education Program for the country in 1951. Doctor Kanner expressed his appreciation to all members of the county medical societies, allied groups, cooperating agencies, and news media for their participation in the 1965 drive.

To Discuss Psychic Drugs

"Abuse of Psychic Drugs" will be the feature address by Carroll L. Witten, M.D., Louisville, president-elect of the American Academy of General Practice, at a luncheon on May 22 at the Hotel Fontainebleau in Miami Beach.

The two-day conference, sponsored by the AAGP, includes eleven southeastern states, Puerto Rico, and Washington, D.C. KMA President, Everett H. Baker, M.D., Louisvile, has been invited to this meeting and expects to attend.

"Anesthesiology and Obstetrics" Seminar Set June 4 at U. of K.

"Anesthesiology and Obstetrics" will be the theme of the second annual Postgraduate Course of the department of anesthesiology at the University of Kentucky Medical Center on Saturday, June 4.

The session, which will begin at 9:15 a.m. in Room M 122, is designed to present current thinking in analgesia during labor, anesthetic management for vaginal or Caesarean delivery, and immediate care of the newborn.

Speakers will be members of the departments of anesthesiology and obstetrics at the Medical Center. No registration fee will be charged. The program is acceptable for six accredited hours by the American Academy of General Practice. For further information, write to Marion A. Carnes, M.D., or Dean H. Morrow, M.D., at the U. of K. Medical Center, Lexington, Ky. 40506.

Dr. Forde Elected Ob-Gyn Head

Francis A. Forde, M.D., Middlesboro, was elected president of the Kentucky Obstetrical and Gynecological Society during the organization's annual meeting April 14 and 15 in Cincinnati.

Doctor Forde succeeds Elwood L. Woolsey, M.D., Harlan, as president. Other officers elected were Laman A. Gray, M.D., Louisville, vice-president, and John L. Duhring, M.D., Lexington, secretary-treasurer. An outstanding meeting was reported, with excellent attendance.

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to help relieve pain in common anorectal disorders

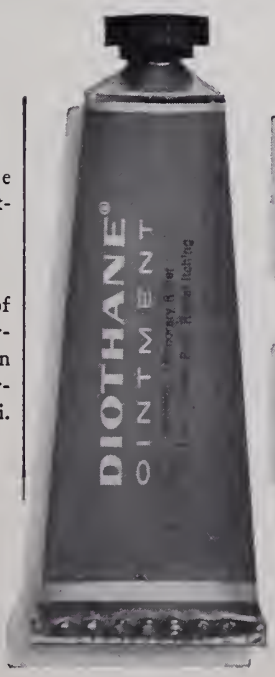
"non-caine" Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





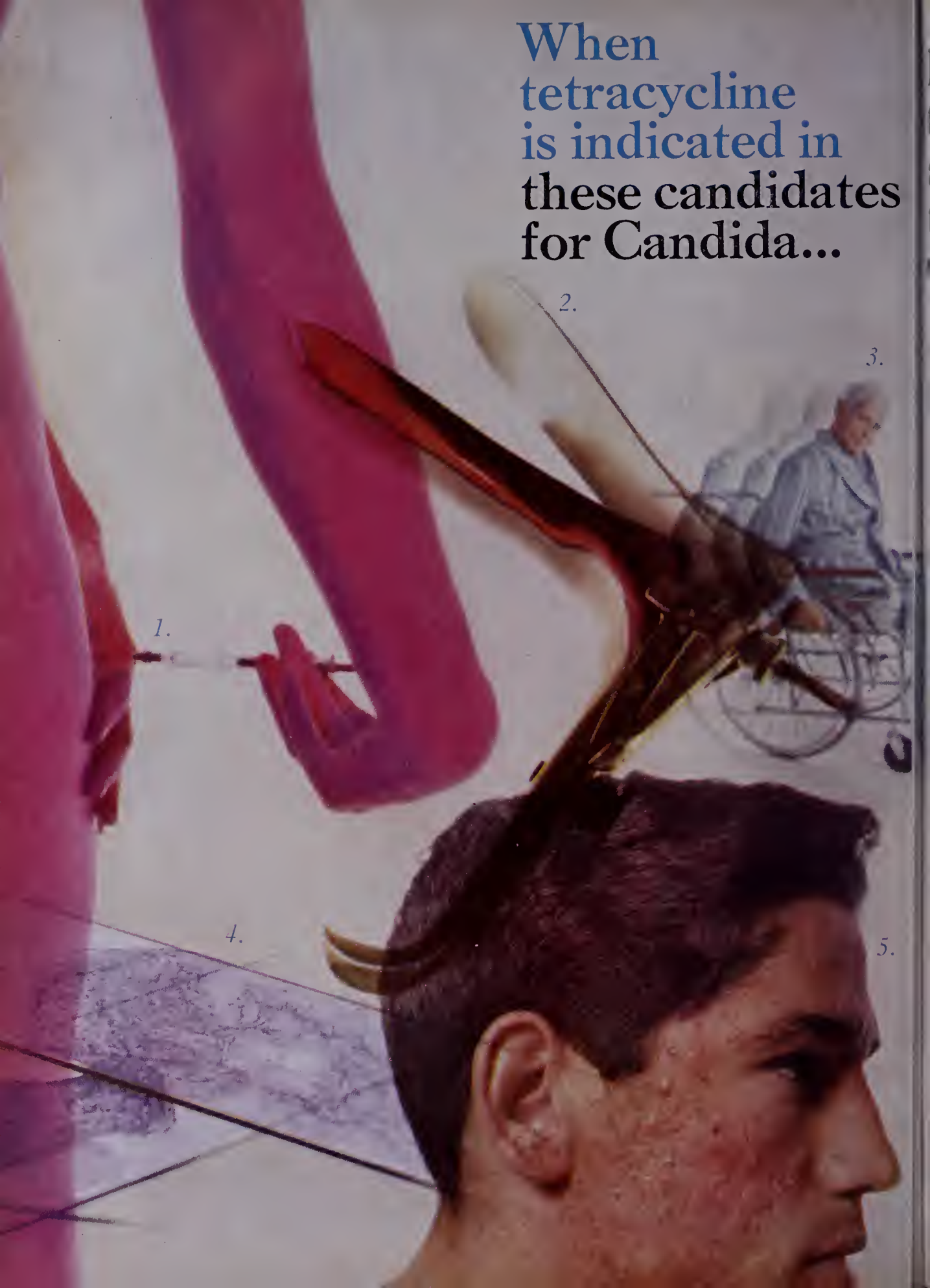
DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

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When
tetracycline
is indicated in
these candidates
for Candida...
1.
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3.
4.
5.

New low-cost tetracycline/ antifungal therapy

Tetrex®-F

tetracycline phosphate complex –nystatin

Because new Tetrex-F (tetracycline phosphate complex-nystatin) is the most economical therapy of its kind that you can prescribe, it is a sound choice whenever tetracycline therapy is indicated in patients predisposed to monilial infections.

Who are these "candidates for Candida"?

1. diabetic patients
2. nonpregnant women with a history of recent or recurrent monilial vaginitis
3. elderly or debilitated patients
4. patients with a past history of moniliasis
5. patients on long-term tetracycline or corticosteroid therapy.

For these patients, Tetrex-F (tetracycline phosphate complex-nystatin) provides efficient tetracycline therapy against a broad range of infections *plus* protection against superinfection associated with the overgrowth of *C. albicans* in the G.I. tract.

Priced for savings

Tetrex-F (tetracycline phosphate complex-nystatin) is lowest in cost—priced 20% lower than most tetracycline/antifungal products.

BRISTOL THERAPEUTIC SUMMARY
For complete information consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.
Supply: Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. Oral Suspension, 60-ml. bottle. Each 5 ml. contains tetracycline equivalent to 125 mg. tetracycline hydrochloride and nystatin, 125,000 units.

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Conference Held in Frankfort To Judge State Health Needs

A Conference on Health Services in Kentucky was held April 11 in Frankfort to assess the future demands on health resources in the state.

Representatives of the medical profession met with others from the state departments of Health and Education, allied health professions, and medical and secondary educators to analyze the future health needs of the state and determine the health programs and health occupations education necssary to meet these needs.

The conferees discussed the responsibilities for developing these programs with emphasis on the education of young people to meet the demands of the different health services, as well as the facilities needed for health care and training.

Occupational Health Meeting Held

Kentucky physicians and others interested in occupational health were among the approximately 190 people attending the second annual Governor's Conference on Occupational Health in Louisville March 27 and 28, according to Gradie R. Rowntree, M.D., Louisville, conference chairman. The theme of the conference was "The Supervisor's Role in Occupational Health and Safety".

Ky. C. of C. Marks Anniversary

The Kentucky Chamber of Commerce celebrated the 20th anniversary of its founding at a special Anniversary Dinner at the Phoenix Hotel in Lexington on April 18. Rexford S. Blazer, Ashland, former past-president, was the main speaker at the dinner, at which all past-presidents were honored.

KMA Council and Committee Reports

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

KMA Headquarters Office **March 31, 1966**

The KMA Hospital Committee recently held its second meeting of the associational year at the Headquarters Office. Representatives of the KMA attended and joined in the continuing discussion on methods of implementing Resolution A, passed by the KMA House of Delegates in September 1965. The chairman of the Hospital Sub-committee gave a report on progress made to date. The resolution pertained to administrative relations between hospitals and private practitioners of medicine practicing within hospitals.

Other items receiving considerable discussion included area-wide hospital planning, Appalachian Regional Hospitals, and a medical record central clearing house.

The committee is scheduled to meet again on May 19 when further discussion will be held on Resolution A.

(Continued on Page 442)

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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



First aid for a button popper



Second aid for a button popper

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By providing combined anorexigenic-tranquilizing action, BAMADEX SEQUELS Capsules help your nonshrinking patients to establish new patterns of eating less. The amphetamine component suppresses the appetite, while the meprobamate helps allay nervousness and tension. And for most patients, the *sustained* release of the active ingredients makes possible convenient one-capsule-a-day dosage.

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phenylbutazone	100 mg.
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In rheumatoid arthritis—effective therap with minimal chance of G-I upset

Therapeutic Effects
Fifty to 75% of patients obtain major relief of arthritic symptoms, as reported by numerous clinicians. In addition, the problem of gastric upset—a major problem with certain other oral antiarthritic agents—is minimized by the presence of antacids and an antispasmodic in the formulation.

Improvement is generally seen within 3 to 4 days, and trial therapy need not be continued beyond a week. Relief of pain is followed quickly by resolution of inflammation and improved joint function. Relief of symptoms is often accompanied by increased appetite, gain in weight and an improved sense of well-being.

The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactio have been reported but cannot definitel attributed to the drug. Thrombocytopeni purpura and aplastic anemia are also po sible side effects. Confusional states, agitation, headache, blurred vision, opti neuritis and transient hearing loss have been reported, as have hepatitis, jaundi and several cases of anuria and hematu With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage in Rheumatoid Arthrit
Initial: 3 to 6 capsules daily in divided do It is usually unnecessary to exceed 4 ca sules daily. A trial period of 1 week is ad quate to determine response; in the abs of favorable response, discontinue.

Maintenance: An effective level is often achieved with 1 to 2 capsules daily; do n exceed 4 daily.

Also available:
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AFTER TREATMENT WITH
'NEOSPORIN' ANTIBIOTIC OINTMENT
AND SALINE COMPRESSES

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Polymyxin B-Neomycin-Bacitracin OINTMENT

Each gram contains:

'Aerosporin'® brand Polymyxin B Sulfate ..... 5,000 Units

Zinc Bacitracin ..... 400 Units

Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) ..... 5 mg.

Tubes of ½ oz. and 1 oz.

- clinically effective
- comprehensive bactericidal action against most Gram-negative and Gram-positive organisms, including Pseudomonas
- rarely sensitizes

For the eradication of infectious organisms in a wide range of dermatologic disorders: impetigo, ecthyma, pyodermas, sycosis vulgaris, paronychia, traumatic lesions, eczema, herpes and seborrheic dermatitis. Prophylactically, for protection against bacterial contamination in burns, skin grafts, incisions and other clean lesions, abrasions and minor cuts and wounds.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindication: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.

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are relieved by direct musculotropic action with.....

Trocinate®
BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

Trocinate *BRAND* THIPHENAMIL HCl
BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

Directly relaxes smooth muscle spasm
Combats hypermotility
Non-mydriatic, may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be virtually free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

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McDowell Home Committee

Laman A. Gray, M.D., Louisville, Chairman

The KMA McDowell Home committee, at a recent meeting, finalized plans to present an exhibit on the McDowell House at the Annual Meeting of the American College of Obstetrics and Gynecology in Chicago during May and at the 1966 KMA Annual Meeting.

The committee members approved a proposed project of the Woman's Auxiliary to KMA which hopefully will result in a new kitchenette for the McDowell House. The summer tourist season was discussed and plans to provide ample hostesses in the house were made. Gifts consisting of items for the grounds and portraits of Doctor Ephriam McDowell's relatives were accepted with appreciation.

A recommendation was made to change the name of the committee from McDowell Home to McDowell House Committee.

COUNTY SOCIETY REPORTS

McCracken

The regular March meeting of the McCracken County Medical Society was held at the Paducah Country Club. Donal D. O'Sullivan, M.D., pathologist at Lourdes Hospital in Paducah, presented the program, a talk entitled "Medicare — The Pathologist — And You".

Walter R. Johnson, Jr., M.D., Society president, presided over the business meeting which followed.

There ensued a serious discussion of the change in relationships of hospital-based medical specialists. A motion was made to the effect that: 1., All technologists and other personnel under the supervision of the pathologist should be directly employed by the pathologist, and that the pathologist be unhindered from third party intervention in the acquisition of equipment and supplies, and, 2., that all these problems would be best solved by arrangements in which the laboratory in the hospitals are operated by pathologists who have a mutual working agreement with the hospital in which the pathologist is responsible for and pays for all laboratory payroll expenses, capital equipment, his expendible supplies,

(Continued on Page 446)

"ALCOHOLISM is a DISEASE"

The Keeley Institute, Dwight, Illinois, specializes in the individual and group care of those having a drinking problem.

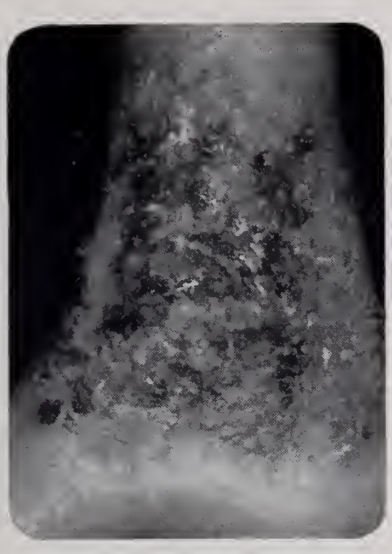
Our progressive, well-rounded program is conducted in an atmosphere of friendly cooperation under the direction of physicians and experienced personnel. We take female patients as well as male.

The alcoholic can be helped . . .

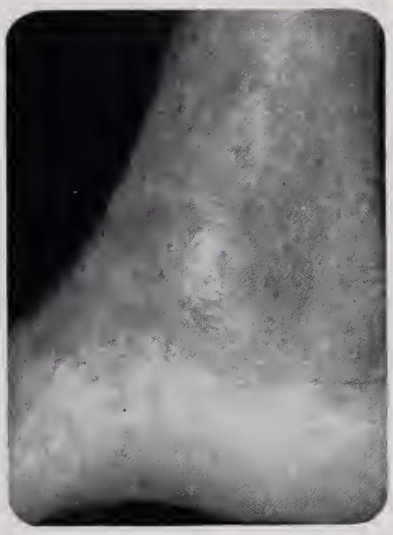
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eczema: scourge of childhood



R. R., Age 11—Before treatment—atopic eczema of long standing



After treatment—with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of childhood eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

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Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide

Also available in foam form and with neomycin.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

(Research and Teaching Exhibits)

1966 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 20, 21, 22**

Fill Out and Mail to:

BENJAMIN B. JACKSON, M.D., Chairman

Committee on Scientific Exhibits

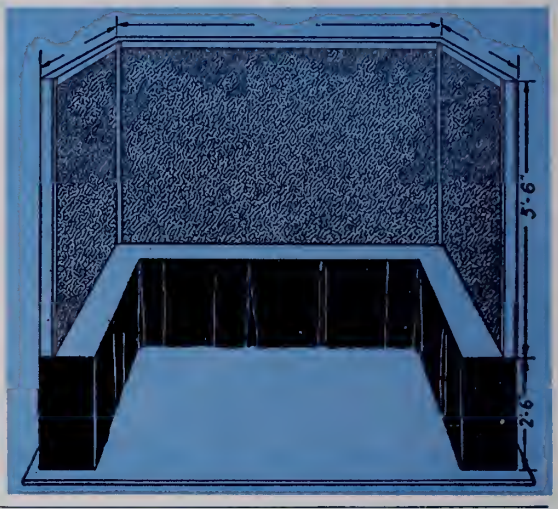
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1966

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....

   .....

   Institution (if desired): .....

   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings .... X-rays....

   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:

   Amount of wall space needed? .....

   Back wall .....Side walls (All side walls are 4') .....

   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Mead Johnson Aesculapius Award of $200.00 and identifying plaque will be presented by the KMA for the best exhibit in 1966.

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

M.D.s Invited to Participate In Family Practice Study

Family physicians from both rural and urban areas are being invited to take part in a summer project designed to study the content of a family physician's practice in Kentucky, scheduled for June 14 to August 11.

The project, supported by a grant from the U.S. Public Health Service, is under the direction of Keene A. Watson, M.D. of the department of community Medicine and Joseph Hamburg, M.D. of the department of medicine at the University of Kentucky. The results will be analyzed for use in improving the newly-established family medicine residency at the Medical Center.

A medical student interested in family practice will spend approximately one week in the office of the participating physician, documenting the content of the practice. No expense will be incurred by the physician. For information contact Doctor Hamburg by writing to the Medical Center, or call collect (Area code 606) 255-3600, Extension 5671.

Two Ky. M.D.'s Serve in Africa

Donald Chatham, M.D., Shelbyville, a member of the KMA Board of Trustees, returned April 28 from Ghana, West Africa, where he spent a month relieving a medical missionary friend of his duties.

E. Truman Mays, M.D., assistant professor of surgery at the University of Louisville School of Medicine, and Mrs. Mays, were appointed March 10 by the Southern Baptist Missionary Board as medical missionaries to Nigeria. Doctor Mays has resigned his teaching post effective July 1.

Pediatric Seminar Set June 9-11

The Great Smoky Mountains Pediatric Seminar (formerly the East Tennessee Pediatric Association) will hold its annual meeting in Gatlinburg June 9-11. All interested physicians are invited to attend.

For information, write to John C. Rochester, M.D., secretary-treasurer, Great Smoky Mountains Pediatric Seminar, 4807 Newcom Ave., N.W., Knoxville, Tenn., 37919.

Practical Nurses Hear Dr. Bost Speak at Louisville Meeting

Howard L. Bost, M.D., new deputy director for Medicare and former U. of K. faculty member, was the keynote speaker at the opening assembly of the annual convention of the National Association for Practical Nurse Education and Service (NAPNES), in Louisville April 18-21.

Almost 1,000 licensed practical nurses, nurse educations, practical nurse students, and guests, attended the meeting at the Kentucky Hotel.

Doctor Bost, who spoke on "Medicare and the Practical Nurse", was assistant vice president for program and policy planning at the U. of K. Medical Center and professor of medical and hospital economics until he resigned this spring to take his current post. The Kentucky State Association of Licensed Practical Nurses is a constituent member of NAPNES.

NEWS ITEMS

William A. Weldon, M.D., Glasgow, was honored May 1 in "Doctor Weldon Day" ceremonies by the citizens of Barren and adjoining counties. Various civic and fraternal organizations sponsored the program citing Doctor Weldon's many years of practice and his contributions to the area.

Philip D. Hitchcock, M.D., who was in general practice at Edmonton for the past six years, has become associated with the McCormack-Wilson-Clinic at Bowling Green. A native of New York, he was graduated from the University of Louisville School of Medicine in 1958, and interned at St. Elizabeth Hospital in Dayton, Ohio.

Frank G. Garbin, M.D., has joined **John J. Sherman, M.D.,** and **Frances R. Sherman, M.D.,** in practice at Martin. Doctor Garbin, a general surgeon, graduated in 1955 from the University of Tennessee School of Medicine and interned at St. Joseph Hospital in Memphis before becoming a resident at San Juan City Hospital, Santurce, Puerto Rico. He previously practiced at Pikeville, Bay St. Louis, Miss., and Jenkins, Ky.

In Memoriam

JOHN W. TAYLOR, M.D.

Stamping Ground, Ky.

1880 - 1966

John W. Taylor, M.D., 85, a general practitioner in Scott, Owen, Grant and Franklin Counties for 63 years, died March 22 at Georgetown after an illness of four months. Doctor Taylor, who received his medical degree from the Hospital College of Medicine in 1903, was an emeritus member of KMA and had maintained his practice until he became ill.

JOHN M. ENGLISH, M.D.

Elizabethtown, Ky.

1879 - 1966

John M. English, M.D., 86, retired Hardin County general practitioner, died April 16 at his home in Elizabethtown after a long illness. He had practiced in Elizabethtown since 1904. Doctor English, who was graduated in 1902 from the Hospital College of Medicine in Louisville, was a past president of the Hardin County and Muldraugh Hill Medical Societies.

depreciation, research and development costs, and all other operating expenses, and rmits to the hospital only those monies necessary to pay for space, ordinary utilities, and what maintainence support as required by the pathologist. The motion was seconded and carried unanimously.

Following this the motion was made that "We therefore recommend that the charges for the services of Radiologists in the state of Kentucky should be established, billed, and collected by the Radiologists in the same manner as all the fees of other physicians." The motion was seconded and carried unanimously.

Following is a list of recently reported county medical society officers. Others will be listed in June.

Boone

President, Howard Ravenscraft, M.D., Hebron; vice-president, Philip B. Schworer, M.D., Florence; secretary, James R. Schrand, M.D., Florence; treasurer, William M. Waller, M.D., Walton; delegate, L. C. Hess, M.D., Florence.

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President, James E. Johnson, M.D., Millersburg; vice-president, John C. Hagan, M.D., North Middletown; secretary-treasurer, Harry Galloway, M.D., Paris; delegate James L. Ferrell, M.D., Paris; alternate, Richard J. Wever, M.D., Paris.

Breathitt

President, Robert E. Cornett, M.D.; vice-president, Price Sewell, Jr., M.D.; secretary-treasurer, F. C. Lewis, M.D.; delegate, Doctor Cornett; alternate, Doctor Sewell. All are from Jackson.

Calloway

President, Conrad H. Jones, M.D.; vice-president, Harry U. Whayne, M.D.; secretary-treasurer, James R. Ammons, M.D.; delegate, Thomas L. Parker, M.D.; alternate, Hugh L. Houston, M.D. All are from Murray.

Carroll

President, Hugh C. Williams, M.D.; vice-president, James D. Ford, M.D.; president-elect, Carl Boylen, M.D.; secretary, Doctor Williams; treasurer, E. S. Weaver, M.D.; delegate, Doctor Weaver; alternate, Doctor Ford. All are from Carrollton.

Henderson

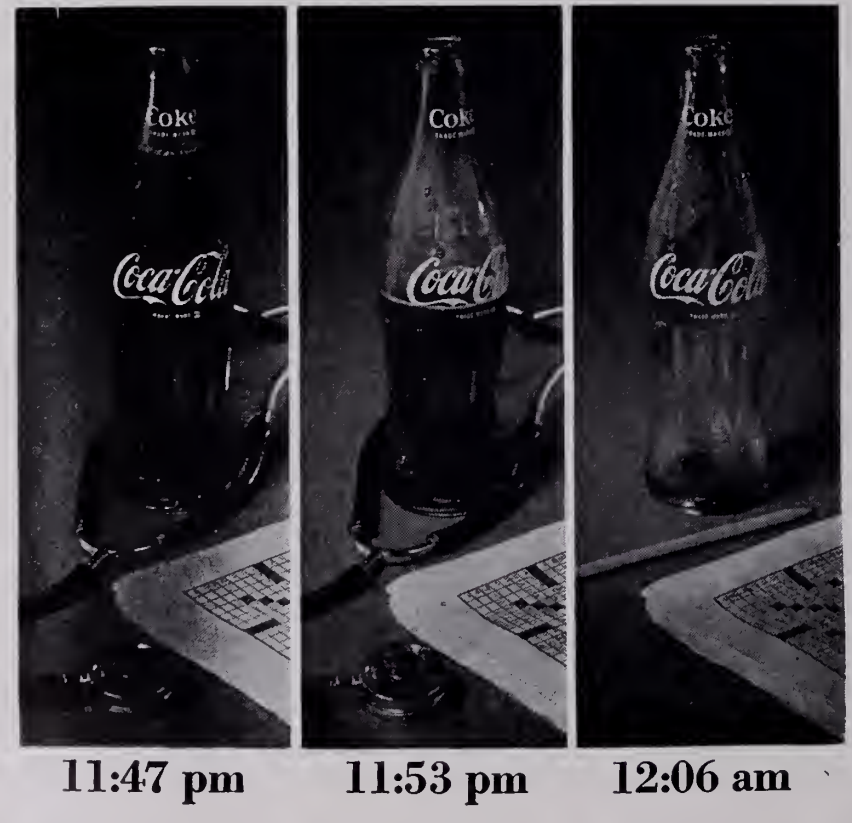
President, John Marchand, M.D.; vice-president, G. A. Buckmaster, M.D.; secretary-treasurer, John L. Jenkins, M.D.; delegate, Charles Kissinger, M.D.; alternate, M. G. Veal, M.D. All are from Henderson.

Jessamine

President, V. C. Gillispie, M.D., Wilmore; secretary-treasurer, J. S. Williams, M.D., Nicholasville; delegate, Doctor Williams; alternate, Dale E. Dunkelberger, M.D., Wilmore.

Lawrence

President, Arthur B. Richards, M.D.; vice-president, Roy L. Clemmons, M.D.; secretary, George P. Carter, M.D.; delegate, William J. McNabb, M.D.; alternate, Doctor Richards. All are from Louisa.



The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke
TRADE-MARK



Answers to Questions About Your Blue Shield

QUESTION: Why does Blue Shield request that the surgeon's claim be filed before an anesthesia claim is paid?

ANSWER: *In most Blue Shield contracts, the anesthesia allowance is a percentage of the scheduled surgical allowance; consequently, knowing the exact surgical procedure and the allowance thereon is necessary to determine the anesthesia payment. In addition, anesthesia allowances are made only when an allowance was also made for the surgery.*

QUESTION: If I treat a Federal employee from another state, how do I file the claim?

ANSWER: *File the claim with Kentucky Blue Shield. Be sure to give the patient's identification number.*

QUESTION: If my patient does not have a Blue Cross-Blue Shield identification number, can I file a claim using his Social Security number?

ANSWER: *Not unless he is an employee of the Southern Bell Telephone Company, Western Electric, or American Telephone and Telegraph. These companies presently use the Social Security number as identifying numbers.*

QUESTION: When does Blue Shield make an allowance for diagnostic x-ray examinations?

ANSWER: *When the x-ray examination is given because of a traumatic injury or when the patient has a special (group) diagnostic x-ray and laboratory endorsement as described on page XV, Participating Physicians' Manual, Schedules C and D.*

QUESTION: When the claim form does not have enough space to adequately describe a complicated surgical procedure, what should I do?

ANSWER: *Attach a written description of the complication or a copy of your operative report.*

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run th
gamut of home remedies without succes
pleasant-tasting CREMOMYCIN can answe
the call for help. It can be counted on t
consolidate fluid stools, soothe intestina
inflammation, inhibit enteric pathogens
and detoxify putrefactive materials—usu
ally within a few hours.

CREMOMYCIN combines the bacteriostati
agents, succinylsulfathiazole and neomy
cin, with the adsorbent and protective d
mulcents, kaolin and pectin, for compre
hensive control of diarrhea.

Indications: Diarrhea. *Contraindications:* Kaoli
Withhold if diverticulosis is present or suspecte
Precautions: Sulfonamide: Continued use requir
supplementary administration of thiamine and vit

your ℞ for Cremomycin can provide relief



in K. Neomycin: Patient should be observed for
ew infections due to bacteria or fungi. *Side Effects:*
ulfonamide: Sensitivity reactions may occur (e.g.,
kin rashes, anemia, polyneuritis, fever; agranulo-
ytosis with a fatal outcome has been reported).
eduction of thiamine output in the feces and of
tamin K synthesis has been observed. Neomycin:
ausea, loose stools possible.
efore prescribing or administering, read product
ircular with package or available on request.

romptly relieves diarrheal distress

Cremomycin®

NTIDIARRHEAL

omposition: Each 30 cc. contains neomycin sulfate
00 mg. (equivalent to 210 mg. of neomycin base),
uccinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0
m., pectin 0.27 Gm.

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here today's theory is tomorrow's therapy

Catheters, Bacteriuria

(Continued from Page 407)

5. Many of the cases reported in the past as showing morphological "chronic pyelonephritis" were undoubtedly cases of chronic interstitial nephritis, not due to bacterial infection.

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Medicine's Finest Hour

(Continued from Page 425)

these truths, and let his God and his conscience be his guide, our present dilemma would come to an abrupt end. Our enemies who are actually the enemies of the people would have to seek other political "plums" to get elected. The freedom of medicine would be preserved. Our posterity would read with pride of the honorable decision we made, and say something like the words of the great Winston Churchill, "This was medicine's 'Finest Hour'."

* * *

The annual Rocky Mountain Cancer Conference will be held again this year at Denver at the Brown Palace Hotel, July 15-16. Charles L. Hudson, M.D., now president-elect of the American Medical Association, will be among the speakers, who include national authorities on cancer. For further information, write to: Rocky Mountain Cancer Conference, 1809 E. 18th Ave., Denver, Colo., 80218.

The American Congress of Physical Medicine and Rehabilitation and the American Academy of Physical Medicine and Rehabilitation will hold its 44th Annual Session August 27-September 2 at the Sheraton Palace Hotel in San Francisco. Business and scientific sessions are planned.

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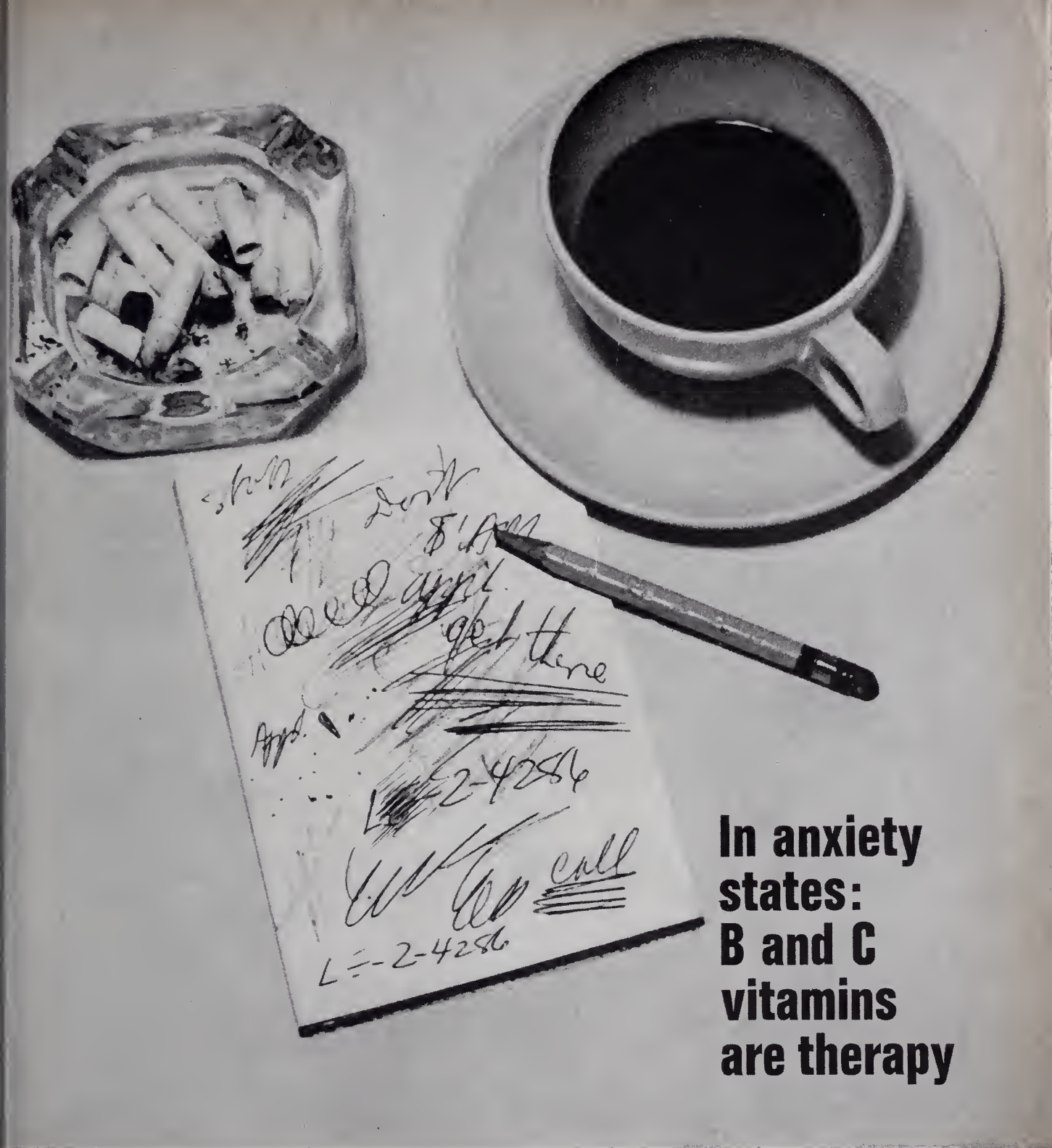
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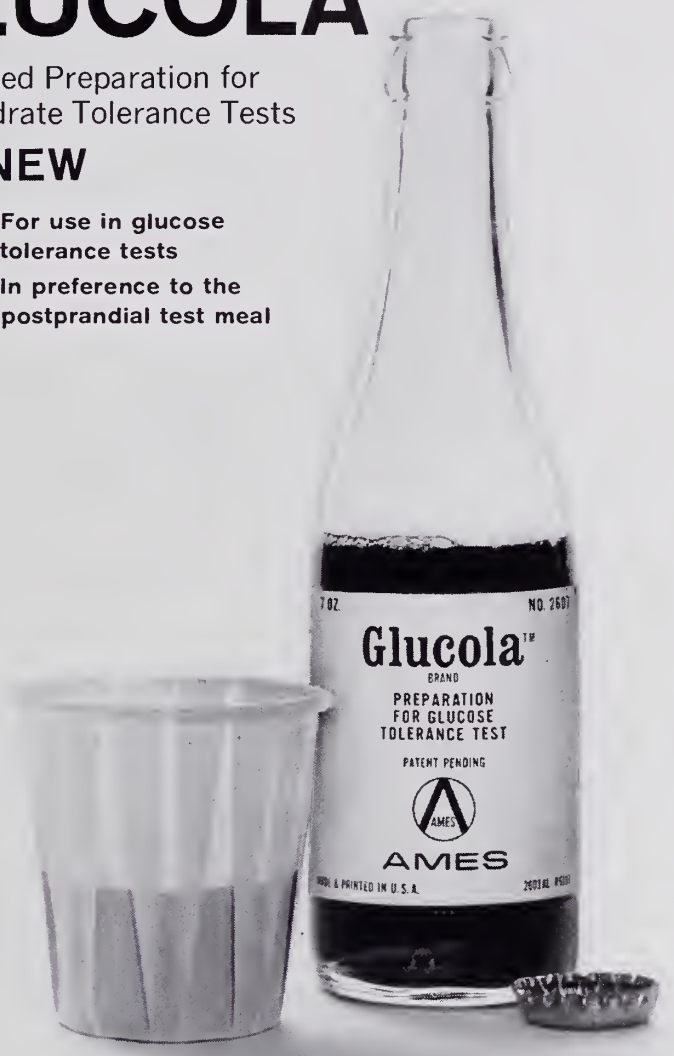
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Precautions: Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, in long-term treatment and in presence of depression or suicidal tendencies. Exercise caution in administering drug to addiction-prone patients or those who might increase dosage; withdrawal symptoms, similar to those seen with barbiturates or meprobamate, can occur upon abrupt cessation after prolonged overdosage. Caution should be exercised in prescribing any therapeutic agent for pregnant patients.

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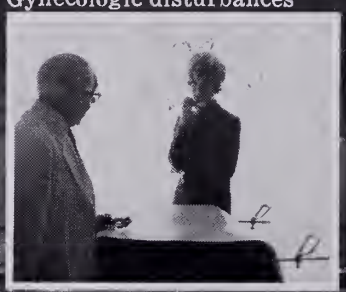
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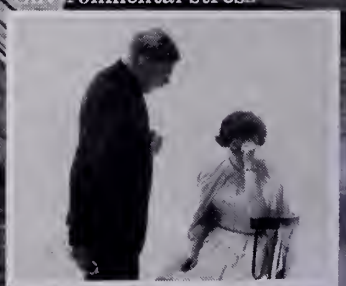
Gastrointestinal disorders



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Walton, M. D.
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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



MAY 2

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MESSAGE FROM THE PRESIDENT



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THE month of June is associated with many things — graduations, weddings, vacations and outdoor activities! June is the sixth month of the year in the Gregorian Calendar, deriving its name from the Roman goddess June.

To us as physicians June means, too, the last of medical and professional meetings until the fall meetings of September and October. The final week of June brings us to the largest and finest medical meeting of the year — the AMA in Chicago. The meeting at McCormick place promises the finest in scientific and technical exhibits and papers by the best educators in the world. Chicago is so close to Kentucky by plane, train, or automobile that the Bluegrass state of Ephraim McDowell and Henry Clay should have its best attendance ever.

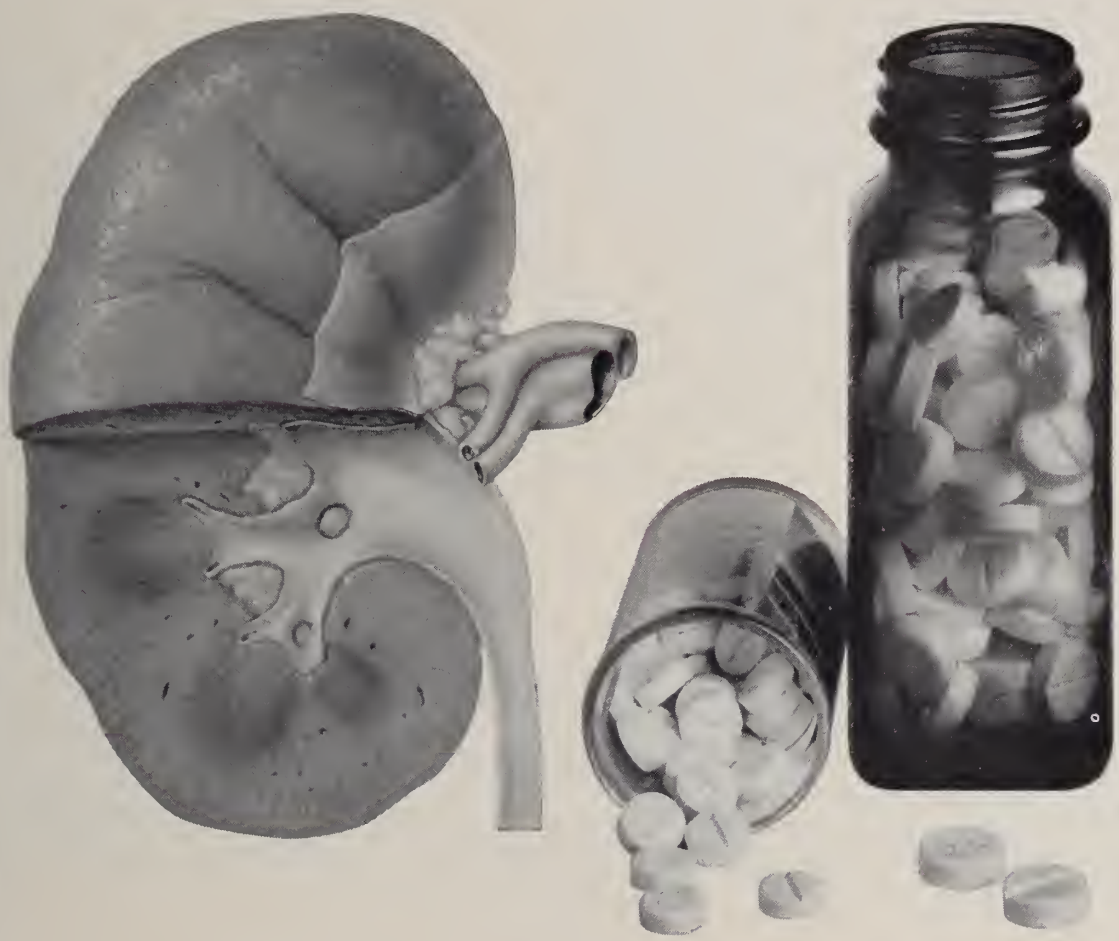
In addition to medical education, there is much in the field of medical legislation of tremendous interest to all of us in these times. Our delegates and alternates will be there studying and voting on every piece of legislation so vital to our patient care and the health of the citizens of our commonwealth and nation.

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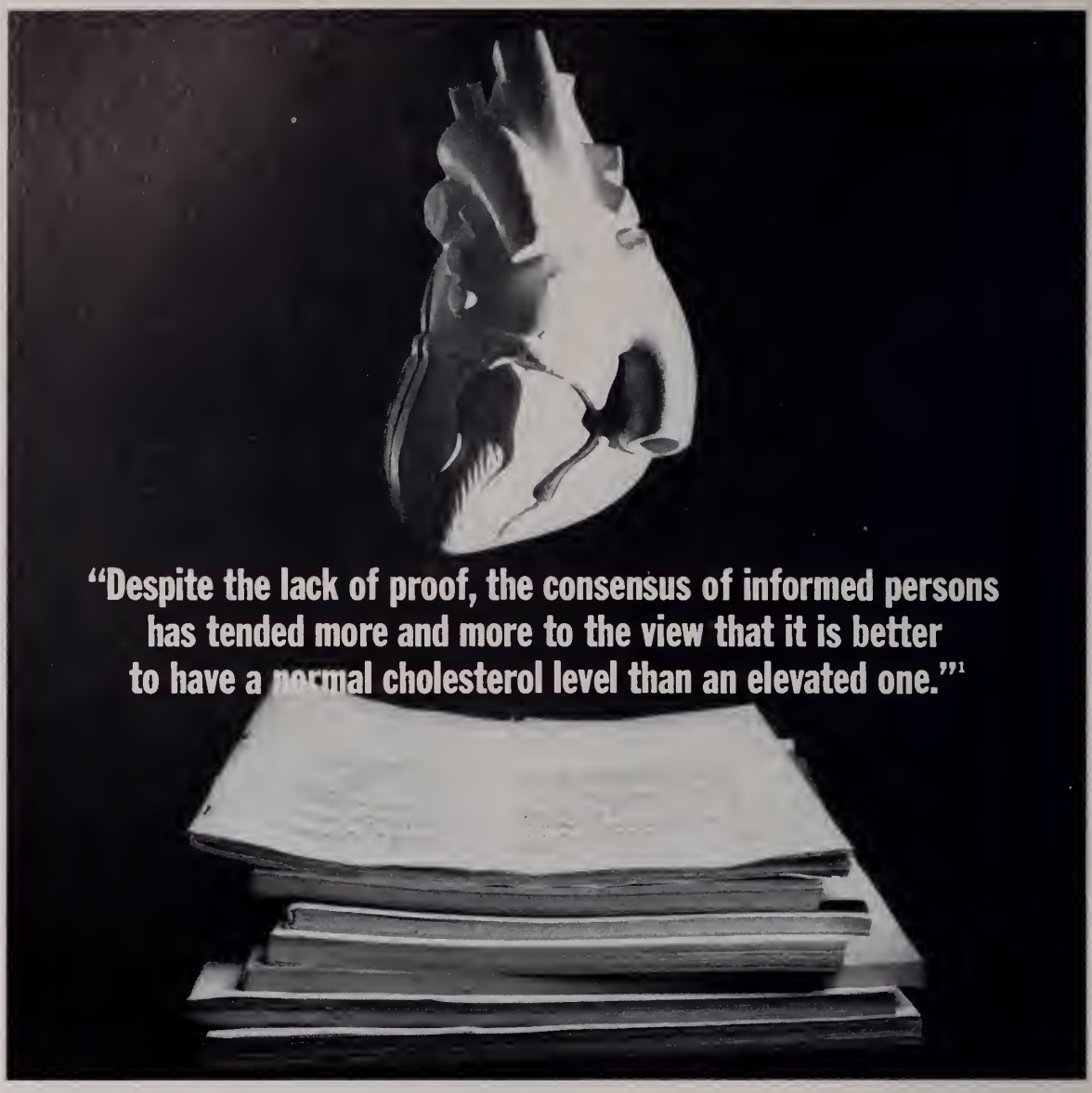
• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

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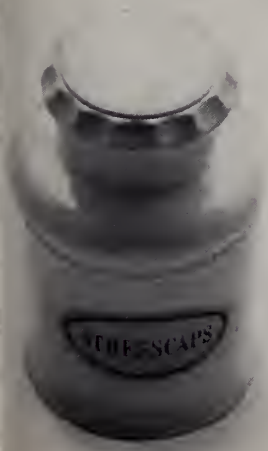
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The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky., 40205.

IN KENTUCKY

JUNE

14	KMA Sixth Trustee District, Bowling Green
16	KAGP Lancaster Seminar, Garrard County High School, Lancaster
30	KAGP Owensboro Seminar, Owensboro

JULY

20-21	KAGP Cumberland Valley Seminar, DuPont Lodge, Cumberland Falls

AUGUST

6-7	KAGP Elizabethtown Seminar, Holiday Inn, Elizabethtown
21	KAGP Bluegrass Seminar, Imperial House, Lexington

SEPTEMBER

20-22	KMA ANNUAL MEETING, Convention Center, Louisville

OCTOBER

6	KAGP Maysville Seminar, Health Department Office, Maysville
27	KAGP Symposium on Clinical Emergencies, Executive Inn, Louisville

IN SURROUNDING STATES

JUNE

23-27	American College of Chest Physicians, Sheraton-Chicago Hotel, Chicago
25-26	American Diabetes Association, LaSalle Hotel, Chicago
26-30	AMERICAN MEDICAL ASSOCIATION Annual Convention, Palmer House and McCormick Place, Chicago

JULY

7-9	American Medical Women's Association, Business Meeting, Sheraton Hotel, Rochester, N.Y.
25-29	Interpretation and Therapy of Cardiac Arrhythmias, Symposium by Hahnemann Medical College and Hospital, at Marriot Motor Hotel, Philadelphia

AUGUST

12-13	AMA National Conference on Infant Mortality, Fairmont Hotel, San Francisco
25-27	West Virginia State Medical Association Annual Meeting, The Greenbrier, White Sulphur Springs
27-Sept. 2	American Congress of Physical medicine and Rehabilitation and American academy of Physical Medicine and Rehabilitation, joint meeting, Sheraton Palace Hotel, San Francisco
29-Sept. 1	American Hospital Association, Palmer House, Chicago

SEPTEMBER

5-12	Third International Congress on Human Genetics, University of Chicago
8-10	American Association of Obstetricians and Gynecologists, Hot Springs, Va.
11-16	Flying Physicians' Association, The Dunes Hotel and Country Club, Las Vegas
20-28	Tenth Congress of the Pan-Pacific Surgical Association, Part I, Honolulu, Ha.
25-30	Michigan State Medical Society Annual Meeting, Pantlind Hotel, Grand Rapids
26-27	Tennessee Valley Medical Assembly, Tivoli Theater, Chattanooga

spring 1966

DORSEY Season

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Duodenal mucosa with ulcer crater—
Approx. 80× Magnification.



Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

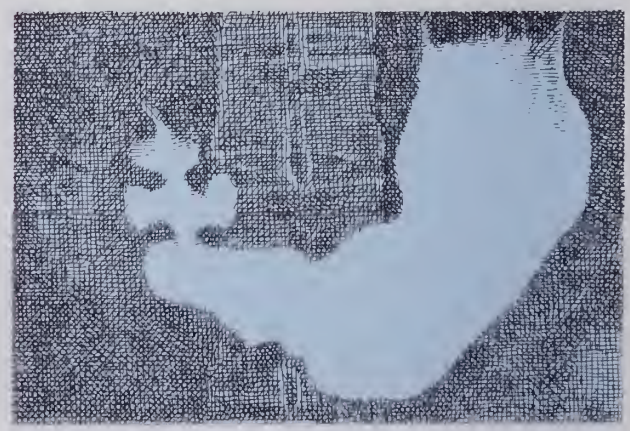
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

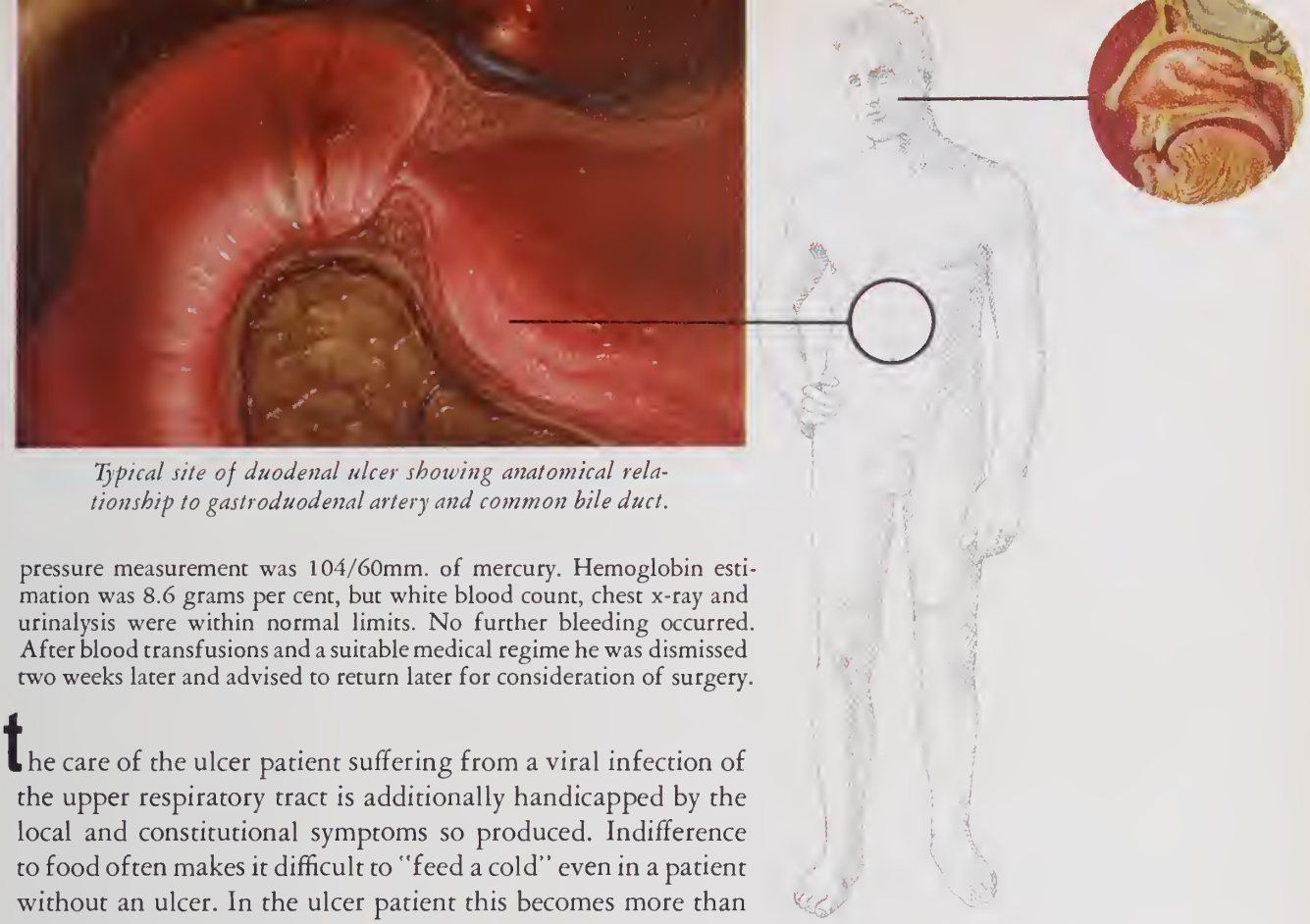
Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



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substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

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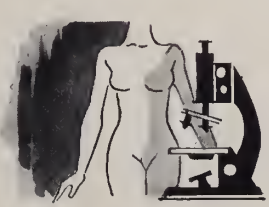


CASE #24-64. This 34 year-old, married, white, gravida 12, para 9 had received adequate prenatal care. Her last menstrual period was March 20, 1964, making her EDC December 27, 1964. Her first pregnancy had been uneventful, her second pregnancy was terminated by low cervical cesarean section for placenta previa. All seven subsequent pregnancies were delivered by repeat cesarean section without incident. After the fourth cesarean section, she was advised to have a hysterectomy, but declined.

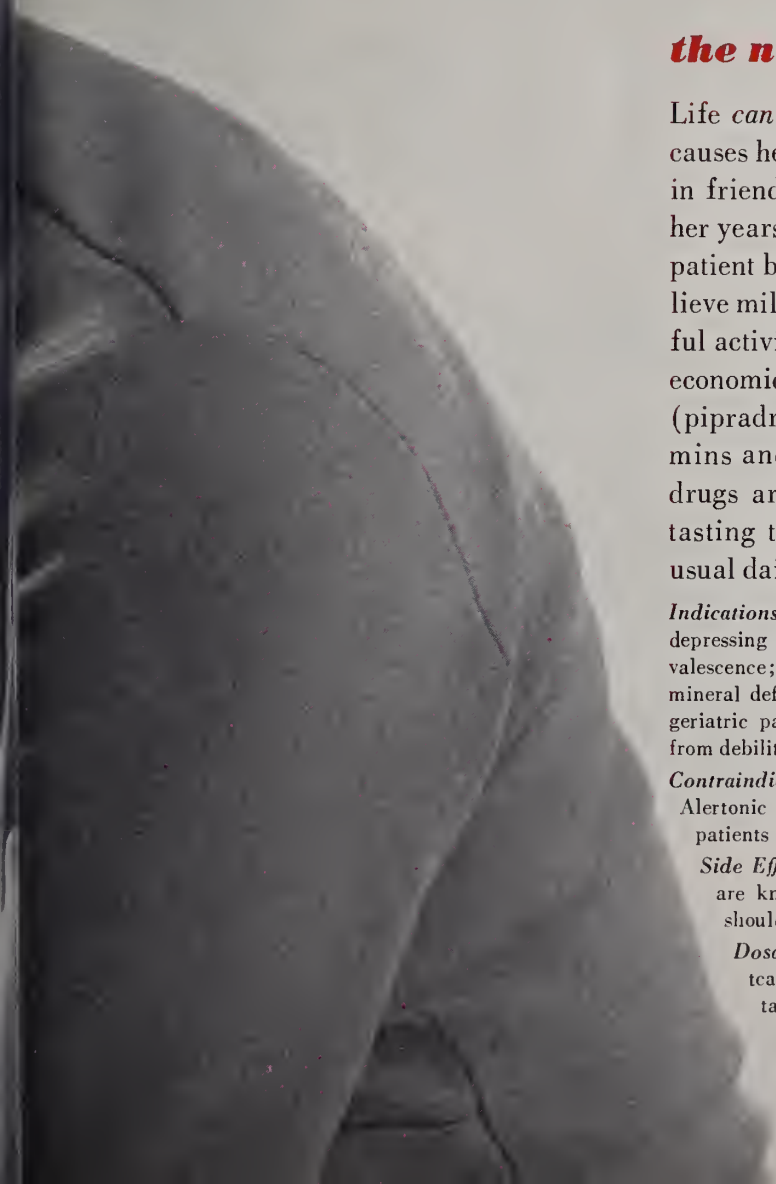
She was admitted to the hospital on December 13, 1964 for elective repeat cesarean section. On admission her temperature was 98.4, her pulse 84, respiration was 22, and blood pressure 130/60. Physical examination was normal and compatible with term pregnancy. Laboratory studies showed a hemoglobin of 11.0 grams %, hematocrit of 34%, a white blood count of 7,700 with a differential showing 86% polys and 14% lymphs. A serologic test for syphilis was non-reactive and she was determined to be Rh positive. The following day, under a combination of spinal anesthesia, sodium pentothal, nitrous oxide, oxygen and cyclopropane, a low cervical cesarean section was performed. A living female child was delivered at 9:25 a.m. Infant respiratory distress was encountered in the immediate neo-natal period. The physician's operative report stated "about the time the dressing was being applied, the anesthetist announced that the patient's pulse had 'suddenly gone bad'. Blood was pumped into both ankle veins after this cardiac arrest had been noted, but to no avail." She was pronounced dead at 11:42 a.m. The autopsy summary notes that, "vigorous and profuse maternal hemorrhage occurred, and in spite of four units of blood the patient went into shock."

The autopsy protocol does not mention free blood in the peritoneal cavity. The uterus was described as large with a low transverse surgical incision, it was thickened, boggy, and edematous. The cervix was soft and not well delineated. The only other abnormal finding was the congenital absence of one kidney. Microscopic examination of the kidney showed hemoglobin and red cell casts within the tubules and destruction of the epithelium of many of the tubules. This was interpreted as being compatible with shock. The final pathologic diagnosis was "shock resulting from exsanguination." The final clinical diagnosis was "Pregnancy of 38 weeks gestation, heart block and irreversible shock."

The committee considered this a direct obstetric death and preventable. The attending physician was present at the meeting and felt the blood loss had been adequately replaced at the time of surgery. It was felt that the most likely cause of death was cardiac arrest due to inadequate oxygenation. Since this should not occur with good anesthetic technique, the committee concluded that this was a preventable death. The use of multiple anesthetic agents could also be questioned. This case vividly demonstrates the often over-looked fact that cesarean section is a major surgical procedure with all the inherent risks for the mother and her child.




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Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

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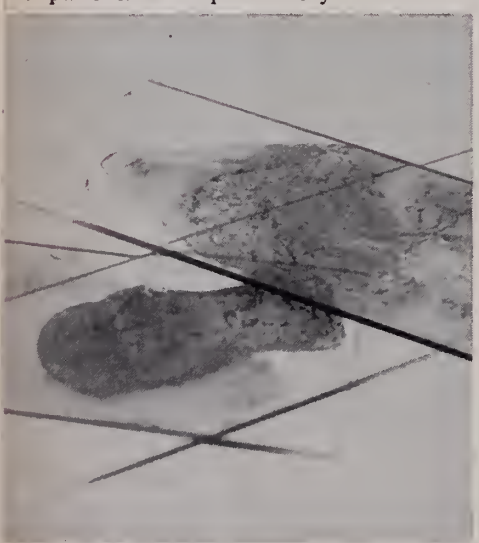
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



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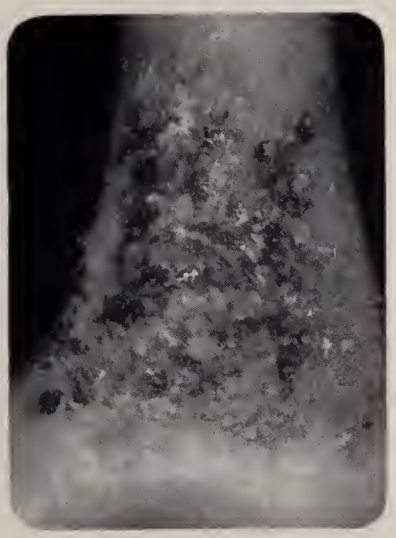
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IN THE BOOKS

RADIOLOGIC DIAGNOSIS IN INFANTS AND CHILDREN: by Armand E. Brodeur, M.D.; Published by The C. V. Mosby Company, Saint Louis, 1965; 503 pages, $26.50.

Doctor Brodeur has produced an excellent monograph devoted to the radiology of infants and children. It systematically covers the organ systems, but because of limited space cannot go into great detail.

The number and character of the x-ray reproductions are outstanding, many of them accompanied by appropriate line drawings. An excellent addition to each chapter is the sub-heading "Pitfalls in Diagnosis." Here, obvious and not so obvious differences from adult radiology are discussed and illustrated.

This volume is intended for those with a general knowledge of adult radiology who wish a rapid and well-organized atlas of pediatric disease as manifested radiologically. Controversial material is at a minimum and the author has stressed findings in his own clinical experience.

The price of this volume might make it somewhat difficult for the average resident to obtain. Unfortunately, the extensive list of references at the end of the volume is arranged alphabetically by author and has no relationship to the subject material in the book itself.

LAWRENCE A. DAVIS, M.D.

THE CELL: AN ATLAS OF FINE STRUCTURE: by Don W. Fawcett; Published by the W. B. Saunders Company, Philadelphia and London, 1966; 448 Pages; Price, $11.00.

It is in the world of subcellular or "fine" structure that physiology, biochemistry, and anatomy find their closest association. No one can hope to understand any of these sciences at this level who does not have some understanding of all of them. Indeed, it is often difficult to say which of them is which.

So far as it can be done, Professor Fawcett has attempted to present in this book the purely morphological side of this world. He has concentrated his attention on the cell itself and reduced to a minimum the consideration of relationships between cells. By this means he has been able to consider for the first time in an atlas of this sort enough of the variety of forms in which the cell organelles are seen to permit the intelligent nonspecialist reader to derive for himself from this one source a reasonable notion of the essential form of each.

Virtually all the figures in the book are of full page size. The quality of reproduction is of the highest. Needless to say, for those who know Dr. Fawcett's work, every micrograph included represents an outstanding example of mastery of electron microscopic technique.

Each figure is commented on in an intelligent and literate fashion on the facing page. Since the illustrations are largely unobscured by labels the reader will be able to judge for himself the perceptiveness of his examination. It is doubtful if any will be able to say that he had come away without learning anything after studying any one of the figures and texts included.

In sum, this book will be of the highest value to those, anatomists or not, who look for understanding of the framework characteristic of life at the level at which life can first be recognized. And for those who have not been in touch with this world before, it will be a source of wonder and beauty.

J. B. LONGLEY, PH.D.

PEDIATRIC THERAPY, Second Edition; edited by: Harry C. Shirkey, M.D.; Published by the C. V. Mosby Company, St. Louis, 1966; 1194 Pages; Price, $18.50.

Pediatric Therapy 1966-1967 is a welcomed and much needed guide through the often confusing and frustrating world of therapy. Frequently the value of an excellent diagnosis is lost by incorrect and inadequate treatment.

The first 119 pages on the fundamentals of drug therapy are required reading for every medical and nursing student. Any doctor who is concerned with the treatment of children should read and understand these fundamental principles. Dr. Shirkey has gathered the experience and opinions of more than 80 well known respected authorities. He has pooled this information in short, concise, easily readable chapters. The reader is not only given the therapy but an understanding of the "why" behind the therapy. It is not a therapeutic "cook book."

The new chapters serve to enlarge the coverage into newer and now better understood fields. The chapters on the surgical subspecialties of neurosurgery and orthopedics cover a few areas of therapy well but because they are incomplete are of questionable value. It would be of value if a chapter on the principles of the treatment of trauma were included.

The bibliographies at the end of each chapter are especially time saving and contain excellent references for those who wish to go deeper into a subject.

This is an excellent book and will find a welcome place on the desk of every doctor responsible for the treatment of children.

VERNON L. JAMES, JR., M. D.

CURRENT THERAPY: edited by Howard F. Conn, M. D.; Published by the W. B. Saunders Company, Philadelphia and London, 1966; 857 Pages; Price, $13.00.

Among the several competent and usable sources of guidance available nowadays, this is perhaps the best-seller. The present edition is the eighteenth. One must agree that the editor's policy of canvassing each year the practices of an almost entirely new committee of experts, is likely to bring fresh knowledge to help the user in his decisions. The emphasis and policy throughout is for reliability and carefully coordinated procedures in treatment. Eccentricities and novelties are few.

The presentations are almost uniformly clearly written and interesting to read. The short, vigorous words and sentences are remarkable for medical writings. Only occasionally has a contributor fond of long words and obscurity eluded discipline.

The editor is to be congratulated on including contributions from four Kentuckians and from two recent ex-Kentuckians. The only important adverse criticism this reviewer can make is of the uncomfortable mass of the book: a little over five pounds.

AUSTIN BLOCH, M. D.

* * *

When physicians encounter an adverse drug reaction it is not uncommon for them to write to the distributor of the drug, possibly in the form of a complaint or as a request for information on similar experience. Reports are often transmitted through the detail man. No one knows as much about marketing experience with a drug as its distributor.—Ralph G. Smith, M.D., in *Journal of New Drugs,* (6:66), January-February 1966.

". . . I would hate to be introducing digitalis as a new drug today. Anyone reading the toxicity and side effects would never use it in the present climate. However, digitalis has been with us long enough now that the toxicity and side effects have taken their proper place. They are there, to be sure, but not as prominently as the theraputic effect.—Robert W. Ballard, M.D., in *Food Drug Cosmetic Law Journal,* (21:31-32), January 1966.

Let us all remember that we must not prescribe just the dosage that is given in a book; we must give enough to produce the effect we desire. Also we must not rigidly prescribe a dose every four hours; it is better to tell the nurse to give enough of the medicine to relieve pain, and when the pain returns to give another dose. I learned much pharmacology years ago when I watched a man quickly drink four martinis. He explained that he did not feel anything until he had four. And then I thought of the many times I had wondered why a man like that had to take three or four capsules of a barbiturate before he felt sleepy.—Walter C. Alvarez, M.D., in *Modern Medicine,* (34:106), March 14, 1966.



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THE INSURANCE PAGE



Blue Shield and Kerr-Mills

IT WOULD be a gross understatement to say that there has been wide spread dissatisfaction with the Kerr-Mills Program as it has been administered in Kentucky. During the early days of its operation the medical profession in this state did everything possible to ensure the successful operation of the program, feeling that with time some of the more obvious defects could be remedied. The profession, working through its appropiate committee, has conscientiously offered constructive criticisms and suggestions for improvements in the administration of the program. Sadly, we have been almost completely unsuccessful in these efforts to streamline the program and make it responsive to the realities of medical practice.

We are now on the threshold of a vast enlargement and expansion of this program by title XIX of the Medicare Program. Title XIX is widely believed to have far greater implications for public health care in this country than the more familiar sections of PL 89-97 dealing with hospital and medical payments for the aged. Title XIX will provide medical care to more than 35,000,000 people, almost twice the number who are eligible under Title XVIII. By July, 1967 any participating state must provide five minimum services: (1) in-patient hospital services (2) out-patient hospital services (3) physicians services (4) skilled nursing home services (5) certain other laboratory and x-ray services. In order to qualify a state must provide these five basic benefits on a "reasonable cost" or "reasonable charge" basis to the aged, blind, disabled, needy families with children, and additional medically indigent catagories according to criteria established by the individual state.

The administration of the health services portion of the program will be the responsibility of a "single agency" of state government. This will be either the health department or welfare department with preference expressed in the wording of the bill for welfare departments. In several states a tug of war has developed between state health departments and state welfare agencies over who will control this vast new program of federally subsidized medical care.

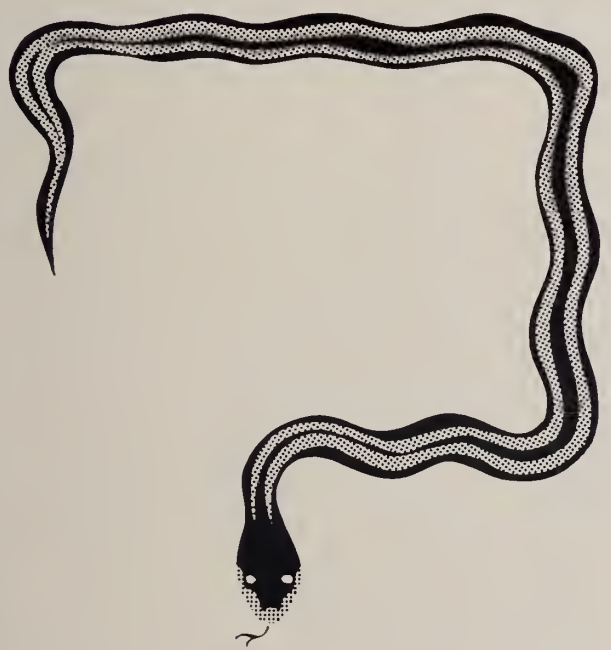
State officials have been informed by the Department of Health, Education and Welfare that there are other possibilities allowed in administering the program. The state agency responsible for the operation of the health services portion, may delegate the administration of the program to outside organizations such as Blue Shield.

Recalling the helplessness of the profession in its efforts to bring about needed basic changes in the state administered Kerr-Mills Program, it would appear that our efforts would better be directed towards attempts at shifting the administration of the program to a non-political organization such as Blue Cross-Blue Shield. This organization has the necessary experience in organizing and administering such a program as well as the staff of experienced professional relations personnel organized to work intimately with practicing physicians. They understand the local practice of medicine, the relationship between the practitioner and the hospital, and between physicians and the local medical society. In several states Blue Shield Plans will serve in this administrative role; the medical profession in Kentucky would do well to promote our own Blue Shield organization to serve in this highly sensitive role in Kentucky.

WILLIAM W. HALL, M.D.

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Supplied: CANTIL (mepenzolate bromide) —25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL —containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



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CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

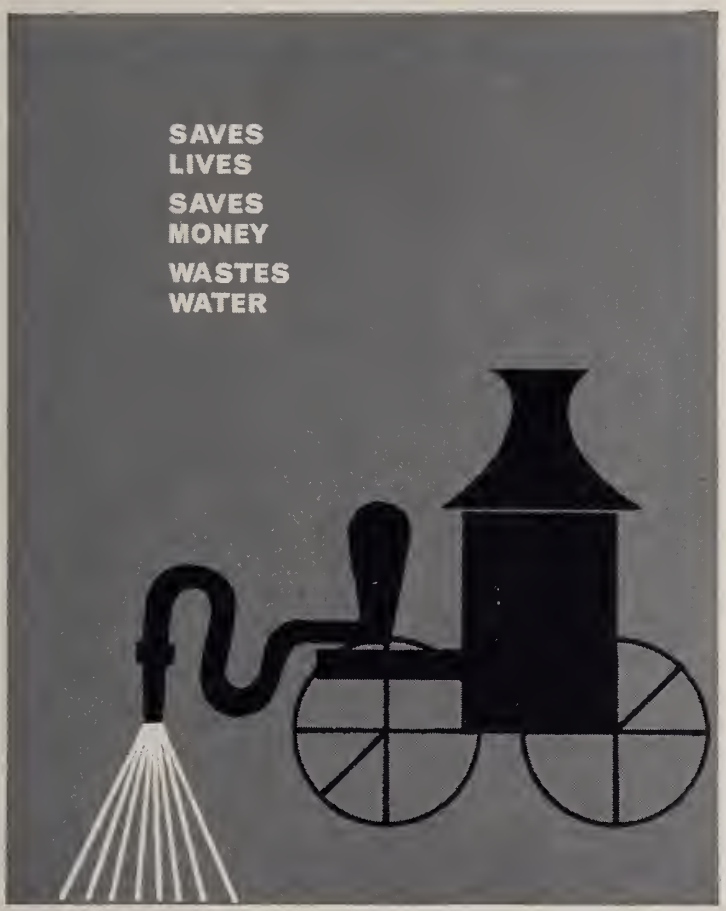
CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

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Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

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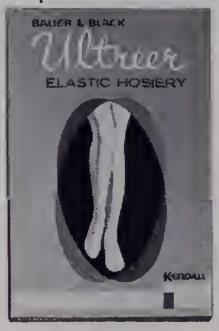
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Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

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Depletion of Storage Iron in the Female: Its Causes, Significance and Treatment

Wilk O. West, M.D.*
Lexington, Ky.

This article on iron deficiency in the female is designed to encourage physicians to administer adequate amounts of iron not only for hemoglobin build-up but to replenish depleted iron stores.

THE importance of keeping a positive iron balance, after making allowances for the normal and abnormal losses of stored iron, cannot be overstated. It is necessary to build up and maintain adequate iron storage in the body. Iron is stored as ferritin and hemosiderin, particularly in the liver, the spleen and the bone marrow, as well as elsewhere in the body.

The normal loss of stored iron in the female may occur through various routes, including an estimated fecal loss of 0.3-0.5 mg. per day,[4] the dermal loss from desquamated epithelial cells and excretion in sweat, shedding of the hair and nails, averaging 0.5-1.5 mg. per day[13] and mostly by menstruation. The average iron loss of normal menstruating woman is estimated at 30 mg. per period, and in anemic women it may be 120 mg. or more.[19] The female requirement of iron during the reproductive period is four times that of the adult male.[9]

*Chief of the division of hematology, The Lexington Clinic, Lexington, Ky.

Causes of Deficiency

Iron deficiency is common in pregnancy and in lactating women, because fetal requirements, the quantity of blood in the placenta and uterus, and the loss at parturition deplete iron stores often already taxed by menstrual losses and perhaps several preceding pregnancies.[16] Childbearing represents a drain of approximately 725 mg. of iron which amounts to an average requirement of 2.7 mg. additionally per day throughout the duration of pregnancy.[10]

It has been estimated that the iron requirement in the female in adolescence is as great as or even greater than in pregnancy.[1] In many cases of hypochromic anemia seen in older women, a history of symptoms extending back to early adult life can be traced.[20] Multiple pregnancies, menorrhagia and hypermenorrhea cause severe iron deficiency.

Anemias of protein malnutrition[3,5] are commonly seen in female patients who are in a state of tension and anxiety, with poor eating habits or those who starve in an attempt to lose weight or for other reasons.

During growth, pregnancy and following excessive loss of blood, it is necessary to administer iron. This may be needed to replenish the normal iron storage in the body or to supply the needed element for the formation of normochromic red blood cells and for tissue needs. Under the conditions of iron deficiency there is nearly complete utilization of administered iron for the formation of red blood cells, and only

a minimum amount is transported to the storage depots of the tissues. After the blood hemoglobin has reached the acceptable levels, it is most important to continue the administration of iron for eight weeks or more to build up the reserve iron storage.[7]

Many factors influence the absorption of orally administered iron. Increased solubility, ease of ionization and the ferrous valence state are properties which lead to greatest assimilation of iron.[14] Maximum absorption of iron is achieved when it is administered on an empty stomach.

Many patients are intolerant to ferrous sulfate, especially those prone to gastrointestinal irritability or with ulcerative disease. Emetic activity often increases during the pregnancy and it enhances sensitivity to orally administered ferrous sulfate. Smith[15] studied the pathology of ferrous sulfate poisoning and Swift et al.[17] reported a fatal case. Luongo and Bjornson[12] investigated the damage caused to the liver by ferrous sulfate poisoning.

Greater gastrointestinal tolerance of organic iron has consistently been demonstrated. Berenbaum et al.[2] studied the acute oral toxicity of iron fumarate, succinate, gluconate and sulfate in mice; sub-acute toxicity in rabbits and the emetic activity in cats. Ferrous fumarate was found to be the least toxic and least irritant of the iron compounds tested.

Giblin et al.[6] found that ferrous fumarate was well tolerated on an empty stomach in a series of fifty patients, including four patients with duodenal ulcers, two with upper gastrointestinal bleeding and two colostomized patients. These investigators used a preparation containing ferrous fumarate combined with ascorbic acid*. Webster[18] found the preparation to be " . . . rational in composition, low in cost and pleasantly flavored." Hanley[8], on the basis of the results of his investigation reported " . . . this preparation approaches the ideal medication for oral iron administration."

The influence of ascorbic acid to produce increased absorption of simultaneously administered oral iron has been stressed in the medical literature. The mechanism of its action is variously explained. A recent editorial[11] summarized the situation as follows: " . . . increased intake of ascorbic acid was associated with increased iron absorption when both were fed at the same time . . . The reducing action of ascorbic acid may help to keep iron in the reduced state and, therefore, may prevent or delay the formation of insoluble or undissociated ferric compounds. Ascorbic acid may play a role in the enzyme transfer system. It appears to be necessary for the incorporation of transferrin-bound plasma iron into ferritin, enhances the release of iron from cell storage to the transport mechanism and increases the transfer of iron into the heme portion of hemoglobin."

Supplied as Vitron-C; Smith, Miller and Patch, Inc. New York, N.Y. 10010.

Methods and Materials

The preparation (Viron-C) was investigated for its therapeutic efficacy, gastrointestional tolerance and patient acceptability in a group of eighy-two female patients from fifteen to eighty-four years of age (Table I). Sixty-six of the patients were married and sixteen were unmarried.

TABLE I
Classification of Paients by Age and Marital Status

Age in Years	Number of Patients Married	Unmarried	Total
15-24	6	5	11
25-34	9	6	15
35-44	27	2	29
45-54	10	2	12
55-64	7	1	8
65-74	4	-	4
75-84	3	-	3
Total	66	16	82

The number of pregnancies ranged from none to twelve. Two married and the sixteen unmarried patients were never pregnant. One thirty-nine year old patient had had twelve pregnancies and another, thirty-six years old, ten. A classification of patients according to the number of pregnancies is presented in Table II.

TABLE II
Classification of Patients by Number of Pregnancies

Number of Pregnancies	Number of Patients
0	18
1	28
2	11
3	13
4	6
5-12	6
Total	82

All patients had hypochromic anemia. Particular attention was paid to establish the etiology of iron deficiency in each case (Table III).

TABLE III
Classification of Patients by Etiology of Iron Deficiency

Etiology	Number of Patients
Menorrhagia	18
Hypermenorrhea	4
Multiple Pregnancies	16
Functional Gastro-intestinal Disturbance	9
Hemorrhoid	3
Malignancy	1
Protein Malnutrition	31
Total	82

Thirty-eight patients had become iron deficient due to menorrhagia, hypermenorrhea and multiple pregnancies. Thirty-two of these patients were severely anemic and showed hemoglobin levels of less than 11 grams.

Protein malnutrition was considered to be the cause of iron deficiency in thirty-one patients. Twenty-two patients included in this sub-group were in a state of anxiety and tension, three had been dieting to correct obesity and six were on greatly imbalanced diets for various reasons.

In one case the iron deficiency had resulted from malignancy. In twelve patients there was evidence of iron deficiency anemia, caused by bleeding hemorrhoids and functional gastrointestinal disturbances.

The patients were ambulatory. They were regularly seen in the clinic at intervals of four to six weeks. Several patients had taken one or the other hematinic preparation on earlier occasions, with varying therapeutic responses. Some patients were unable to tolerate the oral iron preparations they previously used. No patient receiving the test drug was given any other hematinic preparation during the trial period. The prescribed dosage was two to three tablets between meals on an empty stomach daily for three to four weeks, and thereafter a maintenance dosage of one tablet daily for eight to ten weeks.

Results

The patient acceptability of the therapy was excellent and the incidence of gastrointestinal irritability was negligible. Eighty patients, including eight of the nine patients with functional gastrointestinal disturbances, showed no signs of intolerance to the medications. Only one patient with ulcerative disease and another in an anxiety and tension state complained of nausea and gastrointestinal discomfort. These two patients could not take any oral iron preparation.

TABLE IV
Classification of Patents by Therapeutic Response to Vitron-C

Therapeutic Response	Number of Patients
Excellent	26
Good	32
Moderate	19
Poor	5
Total	82

Clinically significant hemopoietic responses were seen in seventy-seven (93 per cent) patients. Five (7 per cent) patients did not receive significant benefits (Table IV). Twenty-six patients classified as "Excellent" showed the final hemoglobin values of 12.5 gm or more. These patients received *full benefit* of the therapy and became hematologically normal. Thirty-two patients rated as "Good" showed significant hematological improvement. The response in nineteen patients was termed as "Moderate". These patients showed an increase of 1.2 to 2 grams in hemoglobin, but the final values remained below 12 grams.

Case Histories

Included in the group were several patients who presented case histories of particular interest to us. A few of these will be briefly described.

Case No. 1-B.G.: A 39 year old housewife with a history of twelve pregnancies presented herself for a physical examination because she had not been feeling energetic enough to carry on her daily routine. The laboratory test showed hemaglobin 10.5 gm, hematocrit 34, R.B.C. 3.9, W.B.C. 6,550 and adequate platelets. After four weeks of Vitron-C therapy, one tablet t.i.d., the patient showed an increase of 2.1 gm in hemoglobin and her blood values became normal.

Case No. 2-M.R.: 57 year old female with a functional gastrointestinal syndrome and hypochromic anemia due to malnutrition. This patient showed an increase of 2.4 gm in hemoglobin after five weeks of therapy, one tablet b.i.d.

Case No. 3-I.G.: 37 year old female with iron deficiency anemia due to menorrhagia and malnutrition. The patient when first examined showed symptoms of chronic anxiety depression and her blood values were hemoglobin 11.8 gm, hematocrit 39, R.B.C. 4.0 million,

W.B.C. 14,800 and adequate platelets. In eight weeks of therapy, the patient felt "like a different person," her hemoglobin rose to 15.0 gm and hematocrit to 45, and W.B.C. decreased to 10,500.

Case No. 4-J.I.: 58 year old female with hemoglobin 9.9, hematocrit 32, R.B.C. 3.7, W.B.C. 7,550 and adequate platelets had pylorospasm and a history of both internal and external hemorrhoids. Within four weeks of therapy her hemoglobin showed an increase of 2 grams and her general hematological status was significantly improved. This patient also received Donnatal® for the relief of pylorospasm.

Conclusion

The results of our investigation indicate that Vitron-C is a well tolerated and efficacious preparation for the treatment of various types of hypochromic anemias commonly seen in adult females. It is free from gastrointestinal irritability often associated with ferous sulfate, and provides the benefits of simultaneously administered ascorbic acid for maximum absorption and utilization of elemental iron.

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McCune-Albright Syndrome: Unusual and Paradoxical Association With Growth Failure in Infancy

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A child who later proved to have McCune-Albright syndrome, a congenital disorder usually associated with normal or accelerated growth, failed to grow. The disorder and implications of the observations are discussed.

"FAILURE-TO-THRIVE" or sub-optimal growth in infancy and childhood is a recurring diagnostic problem. Physicians concerned with infant and child care make a special effort to monitor their patients' growth, for failure-to-thrive can be the first evidence that an infant is not well. Moreover, there are a myriad of causes of growth failure, and good diagnostic accumen may fall short of accurate diagnosis.

This report concerns the authors' experiences with such a case in which the child ultimately developed the syndrome of sexual precocity, areas of skin pigmentation and fibrous dysplasia of bone (McCune-Albright syndrome). The transient, early stunting of growth is paradoxical, and this phenomena has not been appreciated previously in this condition.

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Report of Case

R.A. (Univ. Hosp. No. 01-93-42; born 10 July 1963) is the second child of young, healthy parents. Her older male sibling is normal. The gestation leading to the birth of the patient was complicated by hypermesis gravidarium; the delivery was uncomplicated; weight at birth was five pounds and length was 18 inches. She seemed normal except for large *cafe-au-lait* areas of skin pigmentation; these have persisted as shown in Figure 1.

We first saw the patient a few days after birth because she had become moderately dehydrated secondary to a respiratory infection and diarrhea. She responded quickly to parenteral fluid and antibiotic therapy, and her skin pigmentation and small size were noted.



A B C

FIGURE 1:

A. Large areas of "cafe-au-lait" pigmentation which were present at birth persisted as shown at age 9 months.

B. By age 21 months breast enlargement was present and

C. at 30 months both the pigmentation and bilateral breast enlargement were unabated.

The infant was next seen at the age of five months by referral for failure-to-thrive, lack of vigor and flabbiness of her soft tissues. She was short, but seemed adequately nourished. The skin pigmentation had deepened, and excessive soft hair had appeared on her shoulders and neck. Roentgen studies included an intravenous pyelogram and evaluation of her skull, chest and long bones; these were interpreted as normal.

The patient was evaluated at age six months in the University of Kentucky Birth Defects Special Treatment Center; sub-optimal growth and the previous findings were observed. During the ensuing months the patient was examined on several occassions; weight gain and growth continued at a sub-normal rate. At the age of nine months, because of serum and plasma electrolyte findings suggestive of chronic acidosis, the patient was given an oral alkalinizing solution (Sohl's citrate solution) several times daily. After two months of careful observations, the authors felt the "alkalinizing" solution had had no effect on the patient's growth. The mother, however, felt there had been a beneficial effect and continued the daily use of the alkalinizing solution for five more months.

Observations at age 16 months included roentgenograms of her long bones. Fibrous dysplasia was detected for the first time in most of her long bones as shown in Figure 2. The probability of McCune-Albright syndrome was suggested, and the alkalinizing therapy was discontinued.

In spite of her growth failure, the patient remained in good health and developed motor and mental skills normally. At age 21 months, the patient's breasts began to swell, and scanty amounts of a serosanguineous vaginal discharge appeared. The vaginal secretions ceased after ten days, but bilateral breast enlargement continued. Continued observations over the past year have demonstrated an accelerated growth rate as shown in Figure 3 (See page 498); the child is now normal in size. Her sexual development is limited to enlargement of her breasts. The laboratory studies, in large part, have been normal; these are summarized in Table 1.

Comment

The clinical combination called McCune-Albright Syndrome consists of a primary triad of: (1) fibrous dysplasia of bone, (2) brown patchy pigmented cutaneous lesions ("cafe au lait spots") and (3) precocious puberty. On occasion other problems such as hyperthyroidism, premature skeletal growth, and cardiovascular anomalies may be present. The syndrome usually occurs in females, but it has been described in males.

In 1936 McCune[1] presented a nine-year-old girl with osteitis fibrosa cystica who had precocious puberty, multiple pigmentations of the skin, and hyperthyroidism. In the following year, McCune and Bruch[2] reported complete details of this case under the subject of osteodystrophia fibrosa. Also in 1937 Albright, Butler, Hampton, and Smith[3] reviewed

TABLE 1. SELECTED LABORATORY STUDIES

	NEONATAL (0-1 mo.)	EARLY INFANCY (1-12 mo.)	LATE INFANCY (12-24 mo.)	NORMAL*
CHEMISTRIES: (SERUM/PLASMA)				
Sodium (mEq/L)	145	138,144	143	136-145
Potassium (mEq/L)	7.6	5.2,5.4	5.1	4.1-5.6
Chloride (mEq/L)	91	110,106	109	100-106
Carbon Dioxide (mEq/L)	...	16,18	21.5	20-24
pH	...	7.32	...	7.40-7.45
Calcium (mEq/L)	6.6	4.6	...	4.5-5.5
Phosphorus (mg%)	5.9	3.5,3.6	...	3-7
Urea Nitrogen (mg%)	11	8	22	5-15
Protein Bound Iodine (mg%)	...	6.5	...	4-8
URINE STUDIES:				
Specific Gravity	...	...	1.019	1.002-1.030
pH	6.5	6.0, 7.0	...	4.5-8.0
Proteinuria	neg.	trace, trace	...	neg
Amino Acid Excretion	...	normal	...	...

*For infancy



FIGURE 2: a) and b) At 6 months of age bones of arms and legs appeared normal. c) and d) By age 16 months abnormalities were detected in the long bones. A seeming destructive process in the distal ulna and rare-faction and cortical thinning of the distal femur are shown. e) At age 18 months, the child sustained a pathologic fracture of her tibia and f) and g) by age 30 months generalized ostotic fibrous dysplasia was apparent.

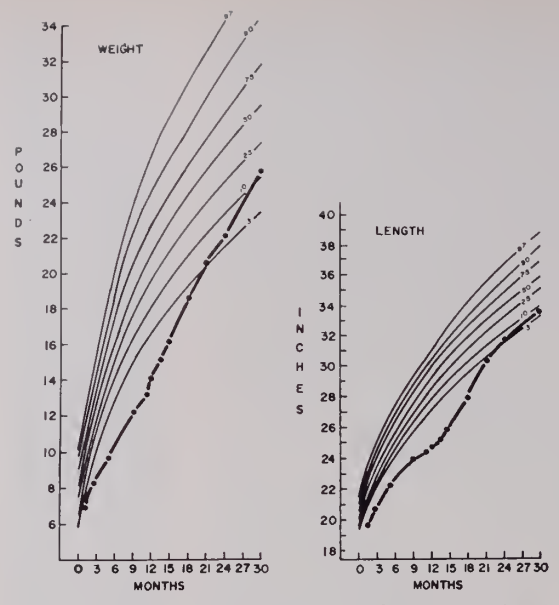


FIGURE 3: Growth curves show the early sub-normal size of the patient with recent return to normal size paralleling the onset of precocious puberty. In time, the child may be excessively large. See page 496.

a number of similar cases and delineated the syndrome. Moreover, they segregated the bone lesions from the fibro-osseous group to which they had previously been attached. These authors stressed the fact that the syndrome was not associated with hyperparathyroidism and named it osteitis fibrosa disseminata to distinguish it from the generalized form of osteitis fibrosa of Von Recklinghansen's. In 1938 Lichtenstein[4] proposed the term "polyostotic fibrous dysplasia", and in 1942, Lichtenstein and Jaffe[5] recognized the monostotic form, and the bone disease became known as fibrous dysplasia. In the intervening years many authors have described this syndrome with its many ramifications under the subject of fibrous dysplasia of bone. Falconer and Cope[6] reported their experience with two cases, pointing out the visual defects that can occur from bony over-growth at the base of the skull compressing the optic nerve and encroaching on the orbit. Their cases were associated with endocrine disturbances and patchy cutaneous pigmentation in addition to the characteristic multifocal fibrous dysplasia of bone. They concluded that, 1) bone dysplasia can occur alone without the other two features of the syndrome and 2) the disease appears in childhood and usually becomes stationary in later life. Prichard's[7] observations led him to believe the disorder is not hereditary, but of course, it is congenital. He postulated a pathophysiologic process as follows: connective tissue proliferation within the medulla replacing marrow, then absorption and replacement of cancellous and cortical bone with metaplastic bone and, occasionally, islands of cartilage and cysts. The roentgen features of fibrous dysplasia are adequately described and discussed with a report of thirty-nine cases by Fries[8]. He dealt primarily with the bones of the skull which usually become involved as the patient ages. Benedict[9] studied the endocrine features of thirty-eight cases of Albright's Syndrome (fibrous dysplasia of bone). Sexual precocity was second only to the bone manifestations as the most frequent feature in her patients. Importantly, she observed that vaginal bleeding and other signs of endocrine abnormality were not associated with ovulation or with demonstrable excretion of follicle-stimulating hormone. A recent series by Harris, Dudley and Berry[10] demonstrates the extreme variability of the clinical course of the McCune-Albright Syndrome. Ninety patients that were diagnosed as having fibrous dysplasia were reviewed, and had or developed the other parts of the syndrome. Also, they showed that the initial manifestations of the disorder may be variable.

Studies of all these reported patients have not demonstrated any consistent biochemical abnormalities. The biochemical alterations observed have usually occurred after extensive bone involvement has developed, and, presumably, are secondary phenomena. Hormone excesses that have been measured have paralleled the clinical findings of sexual precocity, and sometimes hyperthyroidism. All of these reported cases have been studied in late infancy, childhood or adulthood, and, in those associated with sexual precocity, accelerated growth has usually occurred.

Whether failure-to-thrive, as occurred in our patient, is a regularly occurring part of the syndrome is unknown or unappreciated. However, it seems to have occurred in at least two previously reported patients[3, 9]. When contrasted with the later and usual accelerated growth, it is paradoxical. In this instance the syndrome proved to be an unexpected cause of failure-to-thrive. Even though the patient now has achieved normal stature, she may ultimately be abnormally short. This can occur secondary to 1) fusion of the growing

ends of her long bones because of accelerated maturation and 2) the intrinsic abnormality of her bones.

How these congenital anomalies could cause growth failure early is more difficult to explain. We speculate it was secondary to a chronic acidosis characterized by a diminished total serum carbon dioxide concentration and a reciprocally elevated serum chloride concentration. This chronic acidosis, apparently, has cleared. The growth failure probably was not related to growth hormone secretion, since pituitary dwarfs usually grow normally the first year of life. We hope that carefully kept growth records on infants in whom the McCune-Albright syndrome later becomes apparent will document whether growth failure early in life is a regularly occurring phenomena in this rare disorder.

Summary

A young child with McCune-Albright syndrome, who presented with the paradoxical problem of "failure-to-thrive" in infancy, is presented. The history of this syndrome and the evolution of the concept of "fibrous dysplasia" have been reviewed. The significance of the early growth failure and later accelerated growth has been discussed.

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These observations were made in the private practice of one of the authors (G.C.C.) and The National Foundation—Birth Defects Special Treatment Center at the University of Kentucky Medical Center. (UK-BDSTC).

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SEARLE

Research in the Service of Medicine

Oral Glucose Tolerance Versus the Fasting Blood Glucose Determinations†

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The fasting blood glucose values have been compared with the results of glucose tolerance testing. This study confirms the findings of others that early detection of diabetes necessitates glucose tolerance testing with a limited usefulness of the fasting blood glucose level.

LABORATORY tests at present play a a key role in the diagnosis and management of diabetes mellitus. The fasting blood glucose level is widely used as a screening procedure. The adequacy of this test in comparison to the glucose tolerance test for early diagnosis of diabetes mellitus is examined in the present study.

We will stress a few of the valid reasons why a clinician should strive for the early diagnosis of this condition. In some cases of latent (asymptomatic) diabetes appropriate diet, weight reduction and at times the use of oral hypoglycemic agents will reverse the carbohydrate intolerance even after islet cell stimulators have been withdrawn. We do not know whether the small blood vessel complications have been halted and only time and careful study of the results will give this answer. Since the microangiopathies of diabetes are known to preceed carbohydrate intolerance by years we must conclude that there are factors other than high blood glucose levels that damage capillary endothelium. Suggestive evidence from the Joslin Clinic, where "tight control" is the goal in management, should encourage the clinician to strive for the reversal of carbohydrate intolerance, *especially* since there is no other alternative therapy to forestall these crippling effects of diabetes. There is certainly no evidence that associates early "tight control" of carbohydrate intolerance with ill effects provided severe hypoglycemia is not induced.

The sub-clinical diabetic is one who has a normal standard glucose tolerance test in the unstressed state and can be diagnosed only following the use of a cortisone challenge glucose tolerance test. Under an appropriate stress such as pregnancy or infection, the standard glucose tolerance test will become abnormal in these patients, usually returning to normal after the stress is removed. An example of this is the frequent aborter whose chances of carrying a viable fetus to term are greatly enhanced by early diagnosis and therapy.

Many maturity onset diabetics have as a part of their disease the finding of obesity. Recent work on the pathophysiology of diabetes mellitus indicates that the endogenous insulin that they produce is fairly efficient in stimulating glucose metabolism in the fat cell whereas it is defective in its role in catalysing glucose metabolism in the muscle cell. Glucose is actually preferentially shunted to adipose tissue. There is sound evidence to support the claim that the "diabetic is fat because of her disease". Since obesity is associated with many life-threatening diseases it must be treated and it will help the clinician in his role of motivating, guiding and encouraging the patient if he recognizes the association of diabetes with obesity.

All too many diabetics are initially diagnosed in the emergency room in the throes of keto-acidosis, a medical emergency attended by a significant mortality rate. If an early diagnosis is made in these individuals

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this severe complication can be avoided by emphasising that vomiting and physical stress may predispose them to this potentially fatal complication. So forewarned, and with the aid of simple urinary acetone testing methods, this known diabetic could seek treatment before the keto-acidosis becomes severe.

The blood glucose level in the average untreated diabetic patient without keto-acidosis has been thought to be between 100 and 300 mg. %. Critical reports from two large clinics recently have compared fasting blood glucose values with results of the glucose tolerance test and both groups noted that a significant percentage of individuals having normal fasting blood glucose may have a diabetic glucose tolerance test.[1,2] These studies indicate that the fasting blood glucose has limited value as a screening test for diagnosing diabetes mellitus. Results of these studies have prompted us to review the testing procedure in a 300 bed community hospital to determine whether, with a different selection of patients, the findings would be similar.

Methods and Results

Whole blood was analyzed for glucose using the ferricyanide reaction with the Technicon AutoAnalyzer. For glucose tolerance a commercial solution containing 100 gm. of glucose in a volume of 200 ml. of solution was used.

In our laboratory the normal fasting blood glucose levels range from 70 to 100 mg./100 ml. Following ingestion of glucose the one hour blood sugar level should not exceed 160 mg.%. At the end of two hours it should have returned to 110 mg.% or lower. The result is considered equivocal if at the end of one hour the level is 160-170 mg.% or if at the end of two hours it is 110-125 mg.%. The curve is considered definitely abnormal if at the end of one hour the level is over 170 mg.%. or if at the end of two hours it is over 125 mg.%. Both the fasting blood glucose and glucose tolerances curves were analyzed on each of 217 patients. The decision to order these tests were left to the discretion of the several attending physicians. In all instances fasting blood glucose levels were used in the study only when followed by oral ingestion of glucose to determine tolerance. These analyses were divided into six groups on the basis of

TABLE 1

Ronge of Fosting Blood Glucose Levels mg/100 ml.	Normol No.	Normol %	Equivocol No.	Equivocol %	Abnormol No.	Abnormol %	Totol No. Patients
Below 80	80	71.4	8	7.2	24	21.4	112
81-90	26	59	3	6.9	15	34.1	44
91-100	7	21.2	3	9.1	23	69.7	33
101-110	2	16.7			10	83.3	12
111-120					11	100	11
121-130					5	100	5
Totol	115	52.9	14	6.5	88	40	217

the level of the fasting blood glucose. One hundred and twelve patients had fasting blood glucose levels of 80 mg.% or less; 44 had levels between 81 and 90 mg.%; 33 had levels between 91 and 100 mg.%; 12 had levels between 101 and 110 mg.%; 11 had levels between 111 and 120 mg.%; and 5 had levels between 121 and 130 mg.%. From the study of Table 1, it becomes apparent that 69.7 per cent of individuals having a fasting blood glucose between 91 and 100 mg.% had an abnormal glucose tolerance curve. It is also to be noted that 70 per cent of the individuals tested who were found to have abnormal glucose tolerance curves presented with a normal fasting blood glucose value. When the fasting blood glucose level exceeds 110 mg.% the likelihood of an abnormal glucose tolerance curve is 100 per cent.

Discussion

The results of this study, which correspond with the figures from larger clinics, condemn the use of the fasting blood glucose as a diabetic screening procedure. The two-hour postprandial blood glucose has been advocated as the best screening test by many authorities on diabetes and we agree that it is far superior to the fasting blood glucose, although this aspect has not been a part of this study. The glucose tolerance test should be used to confirm the presence of diabetes in cases in which the postprandial blood glucose is abnormal, and should be employed initially when the family history, symptoms, or physical findings give the physician a strong suspicion that diabetes may be present. The difference in price and discomfort to the patient should not be a significant deterrant to this practice.

Early in the evolution of diabetes the islet cells respond to a carbohydrate load by secreting normal or greater than normal amounts of partially effective insulin with peak levels

after the second hour rather than within the first hour as in the case of the non-diabetic. Hyperglycemia is present at the second hour but may disappear several hours later. This explains why the fasting blood glucose, which is in reality a 14-hour postprandial blood glucose, frequently will not identify carbohydrate intolerance in the early diabetic state.

The fasting blood glucose or random blood glucose determinations continue to be of value in diagnosing or ruling out diabetes as an etiologic factor in the dehydrated, comatose patient who presents as an undiagnosed medical emergency. However, a normal fasting blood glucose gives no assurance that a given patient's symptoms of weight loss, malaise, paresthesia, cataracts, or vascular disease (whether renal, retinal, coronary or peripheral) are not related to diabetes.

A recent Public Health survey pointed up the variability of glucose tolerance tests. This report shows that there was an average variation of 34 mg.% at the first hour when the same non-diabetic individuals were retested at two-month intervals.[3] We believe that patients who fall in the equivocal range should be ear-marked for future testing. In the present study 6.5 per cent of the subjects yielded equivocal results, but it is of interest to note that none of these had fasting blood glucose levels over 100 mg.%.

In this study all 16 individuals who had fasting blood glucose levels of 111-130 mg.% proved to have diabetic glucose tolerance curves. This 100 per cent yield of positive results is in agreement with comparable studies done elsewhere. Since the labeling of a patient with a diagnosis of diabetes mellitus carries with it certain penalties, an example of which is an increase in insurance premium rates, the over-diagnosing of diabetes is to be avoided. We do not recommend making this diagnosis on the basis of a single or even repeated fast-blood glucose determinations at the 111 mg.% level. We believe that repeated glucose tolerance tests should be the final arbiter if the physician is in doubt about the presence of diabetes mellitus.

Summary

Fasting blood glucose values were compared with standard glucose tolerance results in 217 patients. If a fasting blood glucose level of 100 mg.% or less had been accepted as sufficient evidence to rule out diabetes mellitus, 62 cases of this disease would have been missed. These 62 cases represent 70 per cent of the total positive tests obtained. Based on our present understanding of diabetes mellitus it would seem that the physician's time and effort and the patient's money is well spent in trying to identify diabetes mellitus in the early stages. This study agrees with the conclusions of others that carbohydrate intolerance is more apt to be recognized if the blood glucose levels are studied after the patient is fed rather than when fasted.

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Carcinoma of the Cervix: Experience at the University of Kentucky Medical Center

JOHN W. RODDICK, JR., M.D.* AND DUANE N. TWEEDDALE, M.D.**

Lexington, Ky.

Two-hundred forty-six cases of cervical cancer seen at the University of Kentucky Medical Center since 1962 are presented. Development at an early age, and diagnosis relatively late in the course of disease is discussed.

THE increasing use of cytologic examination with its obvious value in the early diagnosis of carcinoma of the cervix has produced a marked change in the ratio of non-invasive to invasive cancer. For example, the in-situ to invasive ratio in the period 1949-1957 has been reported as 1 to 35 while in the period 1961-1962 it was found to be as low as 1 to 2.5.[1] Early diagnosis reflects increasing awareness of the disease and increasing use of cytologic methods for its detection. Statistics such as those stated are possible only when interest is keen and mass cytology screening is done. This has been accomplished in Louisville by a community screening program.[2] However, just 74 miles to the east we have encountered a large group of patients in whom the diagnosis of carcinoma in-situ has been made infrequently.

These patients, seen at the University of Kentucky Medical Center, are from the remote regions of Appalachia. Since activation of the department of obstetrics and gynecology in April, 1962, a total of 246 cases of carcinoma of the cervix have been seen. We excluded two because of insufficient data, leaving 244 patients for complete analysis as to extent of disease and age. Of the group, only 35 or 14.3% were carcinoma in situ, an in-situ to invasive ratio of 1 to 7. The remainder were invasive cancer, of which 63.6% were advanced. The breakdown of the patients into age groups demonstrates a remarkable number in the younger age group. (Table 1). Of the advanced cases, 6.8% were under the age of 30 and 22.6% were under the age of 40. The average age of all patients with invasive cancer was 48.2.

TABLE 1.

Relation of age to stage of 244 cases carcinoma of the cervix.

Age	In-Situ	Invasive Localized	Invasive Advanced	Total
20-29	9	6	9	24
30-39	12	23	21	56
40-49	8	19	34	61
50-59	3	17	37	57
60-69	2	9	22	33
Over 70	1	2	10	13
	35	76	133	244

The reasons for the high incidence of invasive cancer in this group of young women can only be surmised. Christopherson and Parker[3] from Louisville have recently documented the relationship of early marriage and pregnancy to the early development of cancer of the cervix as previously suggested by Meigs and others. The majority of the cancer patients seen at the University of Kentucky clinic are from an area in which early marriage is the rule and multiparity frequent. It is not unusual for us to see 13 or 14 year old primigravidas. The 16 or 17 year old multipara is commonplace in our clinic.

Why do we see such a large number of patients with advanced cancer? The answer is probably twofold, related to physician availability and patient attitude. First, there is a high patient to physician ratio in many counties in Eastern Kentucky. Secondly, we have observed that some women are reticent to seek medical care until late in the course of their disease. Not only are advanced stages of disease seen at initial clinic visits but many patients fail to follow through with treatment once their immediate symptoms are relieved. The population in question has tremendously

(Continued on page 541)

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Antigenic Observations of Youth in the Job Corps in Kentucky

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Youth 16 to 22 years of age have received little study from the standpoint of incidence of the common granulatomatous diseases. Experience in a Job Corps center is related.

THE Job Corps is an attempt to elevate the economic status and to motivate the underprivileged of our nation. The Job Corps Training Center in Morganfield, Kentucky, is run by Southern Illinois University under contract from the Office of Economic Opportunity.

The enrollees are male youths between the ages of 16 and 22 years of age who come from all areas of the country. Each Job Corpsman receives a complete physical examination upon reporting to the Center. He then is inoculated against poliomyelitis, smallpox, tetanus, diphtheria, typhoid and parathyphoid, infectious hepatitis and influenza. H eis given a VDRL for reactivity to tuberculin, (Purified Protein Derivative, Intermediate Strength, 5 T.U., Intradermally), to Coccidioidin (Commercial Antigen (Cutter) Intradermally), and Histoplasmin (Commercial antigen (Parke Davis) Intradermally).

From June 1, 1965, through September 5, 1965, six hundred sixty-one Job Corps enrollees were tested. Of these, 42 or 6.4% were found to be P.P.D. positive. Of this total, 2 are Puerto Rican, 2 are Spanish American of Southwestern U. S., 23 are negro, and 15 are white. (Table I).

During the same time, 18 or 2.7% more positive reactors to Coccidioidin. Of these, 12 were negro and 6 white. (refer Table II). There were no positive ractors to Blastomycin. However, 17.8%, or 118, were found to be positive reactors to Histoplasmin. Of the positive reactors to Histoplasmin, 67 were white, 49 negro, 1 is Spanish American and 1 is American Indian. The greatest number of positive reactors to Histoplasmin were from Kentucky with 27 positive reactors, followed by Arkansas with 22. (Table III).

TABLE I
STATES OF ORIGIN
JOB CORPSMEN SHOWING POSITIVE REACTION TO TUBERCULIN

Mississippi	2	Kentucky	3
New Mexico	1	Illinois	4
Arizona	1	Oregon	1
Oklahoma	2	New York	5
Arkansas	4	Louisiana	4
New Jersey	1	Alabama	1
Nebraska	1	Texas	1
Georgia	1	California	2
Maryland	1	Pennsylvania	1
West Virginia	2	Connecticut	1
South Carolina	1	Colorado	2

TOTAL 42

TABLE II
STATES OF ORIGIN
JOB CORPSMEN SHOWING POSITIVE REACTION TO COCCIDIOIDIN

Illinois	1	California	1
Louisiana	4	Kansas	2
Ohio	1	Georgia	1
Arkansas	3	Colorado	1
Oklahoma	2	South Carolina	1
West Virginia	1		

TOTAL 18

TABLE III
STATES OF ORIGIN
STUDENTS SHOWING POSITIVE REACTION TO HISTOPLASMIN

Kentucky	27	West Virginia	2
Arkansas	22	Ohio	2
Tennessee	16	Indiana	2
Oklahoma	9	Iowa	1
Louisiana	8	Virginia	1
Mississippi	6	North Carolina	1
Kansas	5	Illinois	1
Georgia	3	South Carolina	1
Colorado	3	New Mexico	1
Alabama	3	Wisconsin	1
California	3		

TOTAL 118

These figures indicate that the prevalence of tuberculosis as manifest by the tuberculin test is slightly higher in the Job Corpsmen Enrollees. Only 5% of males aged 17 to 20 years are expected to react positively to 5 T.U.,[1] whereas an additional 1.4% above the national average was found in the group tested.

(Continued on page 540)

**Medical Director, Breckinridge Job Corps Center, Morganfield, Ky.*

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Depressive Reaction in a Case of Osteitis Deformans (Paget's Disease)

Nina Kateryniuk, M.D.*

Introduction

DEPRESSION is one of the most common emotional disorders among chronically ill patients admitted to the psychiatry wards. Quite often we deal in such cases with suicidal attempts. The purpose of this case presentation is to demonstrate the correlation between the somatic and psychogenic factors contributing to a psychiatric disorder.

Case Report

The patient is a 51 year old single, white female admitted to the ward from the emergency room after taking an unknown amount of Carbrital.

Chief Complaint: "I took some pills because I couldn't sleep."

Present Illness: The patient was seen by her father on the day of admission; she appeared well. Later on, he found her lying in bed unresponsive. He tried to awaken her but couldn't.

Two weeks prior to admission, she fell on her hip. She had difficulty in getting around since then because of the pain in her hip and back.

She had been taking Carbrital and Doriden for several years "for my pain, restlessness and nervousness." She has been known to have Paget's disease for about six years and had been under treatment by her local physician. In this time she had lost weight from 110 lbs. to 82 lbs. She complained of a constant soreness in her legs and spine and of headaches, more so for the last two years.

In the emergency room, the patient was unresponsive to all stimuli and demonstrated Cheyne-Stokes breathing. Her neck was supple. Her pupils were 3 mm, equal and with no reaction to light. She had no deep tendon reflexes and a blood pressure of 70/0. No friends or family were available for a history.

Family History: The father, aged 77, had arthritis, but was otherwise in good health. The mother died in childbirth when the patient was three years old. Two brothers were both living and in good health. One sister was living and in good health. There were no known familial diseases.

Previous History: The patient had the usual childhood diseases, and there was no history of any surgical procedures or allergies.

The patient completed the eighth grade. She smokes one pack of cigarettes a day and states she is a social drinker.

She worked at a candy plant for 33 years until two years ago, when she became unable to work because of her discomfort. She is on a disability pension and lives with her father who receives social security.

She describes herself as a fairly religious person. She has been unable to go to church for several years, but states that she still prays every day.

Physical Examination: The patient is a rather poorly developed, undernourished white female in no acute distress. The forehead is large and protruding. The blood pressure is 140/70, pulse 80, respirations 20, temperature 98.6°. The liver descends 1 cm. below right costal margin and is soft and non-tender. There are no other significant findings. The neurological examination is within normal limits.

Formal Mental Examination: The patient appears neat and fairly well groomed. She is generally quiet, and appears somewhat depressed. Her time is spent resting in bed and talking with other patients.

Her remarks are relevant and show logical progression, but are somewhat abrupt. She is coherent and cooperative.

Her facial expression is that of a depressed person. Her present attitude is one of regret for what she did. "A person has no right to take their own life until the Lord is ready."

The patient is willing and able to give the history. She has no ideas of unreality or nihilistic ideas. She states that she has been depressed for the past month and has considered suicide off and on for this period of time, but never before. She felt this was the only way because of the helpless feeling about her disease. She is oriented as to place and time. Her remote and recent memory is good. She is of average intelligence. Her insight at present appears good.

Laboratory Data: The laboratory data were within normal limits except for: Calcium: 7.6 mg%, alkaline phosphatase 32.5 mg%, phosphorus 2.7 mg%. An

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x-ray of the skull showed moderate thickening of outer table. The pineal gland was not identified, and the sella turcica was normal. The impression was one of thickening of the outer table of the skull consistent with Paget's disease.

Course in Hospital: During the initial two days following her admission to the ward, the patient had difficulty in concentrating and showed memory impairment. She seemed to be confused on occasions. Her appetite was poor. Gradually she began to appear more alert, showed interest in her surroundings, and related to other people with a cooperative and friendly attitude. She took pride in her appearance and showed good judgment in planning for her future. She was appreciative of the attention given to her, and responded to supportive psychotherapy. Psychological testing revealed no impairment of intellectual function. The medical treatment consisted of high protein, high calcium, high vitamin diet (specifically high in vitamins D and C).

Clinical Consideration: The basic organic pathology in this case was established as osteitis deformans or Paget's disease of the bone. It was important to understand the progress and the extent of the disease and their relationship to the symptoms reported. According to the literature, the thickening of the skull may lead to cerebral compression with consequent headache, epilepsy and mental deterioration. The patient reportedly suffered from headaches, and aches and pain in her extremities; she gave this as a reason for her despondent gesture. The medical and neurological consultations suggested no specific treatment. The psychiatric workup revealed that the patient did not understand the nature of her physical illness, and worried about its course and prognosis. This sounded realistic. "I know I am getting worse; I am getting tired very easily; I never asked doctors questions because I was afraid."

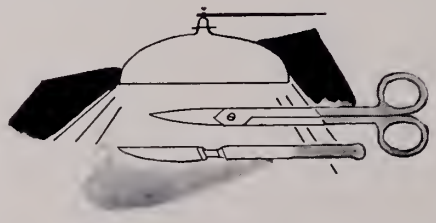
Depressions, in respect to their source, may be classified as reactive or endogenous. In reactive depressions the external causes are obvious. There is a definite suicide risk in many cases of reactive depression, but the suicidal urges usually do not have the severity or the persistence of the suicidal urges of other types of depressions such as the manic depressive or the involutional depression.

Therapeutic Consideration: Although the patient's course in the hospital indicated marked improvement and no clinical symptoms of depression were evident before her discharge, continued hospitalization for a total of at least three to four weeks was recommended for psychotherapeutic purposes. The goals of therapy at this stage of the patient's physical illness were primarily directed toward strengthening of her psychological defenses and acquiring a compromising insight. The patient insisted on leaving the hospital, and an arrangement was made for her follow-up in the outpatient clinic. The patient was also referred to Bridgehaven, a center for convalescing psychiatric patients, where she could profit from group therapy and recreational programs under skilled management.

Summary: In cases of chronic and disabling illnesses, a reactive type of depression often occurs and may lead to suicide attempts. The therapeutic methods are based on the clinical picture and symptomatology; however, the outcome of a therapeutic process limited to supportive psychotherapy depends greatly on a patient's personality make-up. In the case reported, we encountered resistance, manifested by rejection of continued hospitalization and lack of support by the family or responsible correspondents.

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SPECIAL ARTICLES

The Medical Student and His Relationships With The Medical Profession; Recruitment, Selection, Counselling and Attrition

(At the University of Louisville and the University of Kentucky†)

ROY K. JARECKY, ED.D.*

AS DOCTOR WAGNER points out, in 1964-65, 47.2 per cent of the 19,168 applicants for places in medical school classes were accepted. In the same year, 256 residents of Kentucky applied for admission to medical schools and, of these, 151 or 59 per cent were admitted. Of the 151 admitted, 78 per cent enrolled either in the University of Louisville or the University of Kentucky while 33 students or 22 per cent elected to attend out-of state schools. It is of some interest to note that Kentucky was fourth from the top with respect to percentage of applicants actually admitted to a college of medicine. Only North Dakota, South Dakota and Vermont had higher percentages. This is a considerable achievement, since in thirty states, less than 50 per cent of their applicants were admitted. On the other hand, it is equally relevant to point out that the total pool in Kentucky has averaged only 265 applicants for the past seven years. It is important to enlarge this pool in order to insure Kentucky medical schools a continued good quality of selection. Figures provided by the Association of American Medical Colleges demonstrate that attrition is highest when the total applicant pool is small. The larger the pool, the smaller the attrition.

Recruiting

Recruiting for medicine is most effective when in the colleges, both those concerned with going to medical school and those concerned with teaching and advising pre-medical students are knowledgeable about medical school programs. Thus, our recruiting activities have included student visits to medical schools, visits by medical school faculty members to undergraduate colleges and high schools, attendance of pre-medical advisors at medical college admissions committee meetings, and discussions between pre-medical advisors and medical school faculty concerning undergraduate and medical curricula. In the end, however, the most effective preparation for a career in medicine is doubtless done by the individual himself. The person who has the initiative to find out all he can about medicine and who talks with practitioners as well as with medical college admissions officers may well recruit himself without much urging from other parties.

Admissions

Since there are a limited number of places available in each entering class, admission is a highly competitive matter. Admissions committees are not simply concerned with the question of whether or not a given applicant may "pass" if admitted, but rather how effectively and creatively it appears he will be able to deal with a medical curriculum. They must determine how well or poorly an applicant's record compares with those of all others who are applying.

The Admissions Committee of the University of Kentucky College of Medicine attempts to look at more than just the "numbers", i.e., grades, grade point averages, and Medical College Admissions Test scores. This does not mean that these measures of achievement are unimportant. They are important. However, there is much more to preparation for medical school than the securing of a high grade point average. An applicant to medical school must be sophisticated with respect to his education. He must not only comprehend, but be able to discuss the material which he has learned, with some facility and understanding. Certainly his interest in medicine should reflect thought and investigation on his part. Simply to say that one wishes to become a physician without further involvement in the question of what it means to be a physician is insufficient. Unfortunately, some applicants take a very superficial approach to this latter question and

†*Presented by Doctors Jarecky and Wagner at the First KMA Conference on Medical Education at Park Mammoth Resort, January 21-23, 1966. The program was presented in cooperation with the University of Kentucky College of Medicine and the University of Louisville School of Medicine.*

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thus are less well prepared as applicants than others who have achieved the same academic level of performance.

Our Admissions Committee, which consists of nine members, attempts to sift all the evidence made available to it through the admissions process. Each student who appears to be competitive for a place in the entering class is invited to be interviewed on the campus at Lexington, and is seen by three members of the medical school faculty. Each interviewer attempts to get some feeling for the applicant as a person and to better understand what the applicant's record means. This is the applicant's chance to get beyond the "numbers". Since most applicants tend to feel that they are somewhat better than their records, they welcome the opportunity to present themselves in person. Subsequent to the interviews, the Admissions Committee meets and reviews in detail the credentials of each applicant seen the previous week. All aspects of the application are discussed and all members of the committee review the pertinent information. Finally, a vote is taken on whether the applicant should be admitted, rejected or held for further consideration. A simple majority decides.

We are frequently asked whether the various admissions factors such as grade point averages, undergraduate references, Medical College Admission Test scores and so forth are weighted in a particular way. The answer is that they are not. The Committee attempts to look at each person as an individual and does not try to apply a mathematical formula to determine what the disposition of an application should be. If we were to do this, no interviews would be necessary and a computer could do the job of selection quite nicely. Although the Admissions Committee and the faculty interviewers spend some six hundred hours a year on the admissions program, our feeling is that such an expenditure of time is worthwhile. It allows both faculty and applicants to get to know one another and permits a more personalized assessment of each applicant.

The College of Medicine admits approximately 15 non-residents to its entering class of 80. Since hundreds of non-residents apply, competition is exceptionally keen. Only those non-residents are taken who compare very favorably with Kentucky applicants and who appear to have some particular interest in Kentucky and the College of Medicine.

Our attrition rate is approximately 5 per cent of the total student population per year. Naturally, our concern is to reduce this percentage further and to that end we have developed counseling and advising programs whose immediate function is to help students identify and solve personal problems as soon as they appear.

Financing

Concerning the matter of financial aid, during the academic year 1964-65, some 51 per cent of our total enrollment borrowed approximately $200,000 from major loan sources such as American Medical Association Education and Research Foundation, the Health Professions Act loan program and the Rural Kentucky Medical Scholarship Fund. In the current senior class, 66 per cent of the students borrowed a total of $206,368 over the past four years. The average indebtedness of those who borrowed is $4,500. During this four-year period, scholarship aid provided 32 per cent of this class with a total of $23,600; 31 per cent received no financial assistance at all. For the 30 per cent of all our students who come from families with yearly incomes of $6,000 or less, the matter of financing a medical education is always acute.

Conclusion

We would like to bring this article to a close by thanking the Fayette County Medical Society and physicians throughout the state for their interest in our medical students, in the pre-medical students planning to apply here for admission, and in our program. We hope that the information in this article will stimulate communication from any individual physician or county society who wishes to secure more detailed information relative to any of the information reviewed above.

The University of Louisville

Charles E. Wagner, Ph.D.**

IT IS A genuine pleasure to have this opportunity to explain some of the factors involved in the recruitment, selection, counseling, attrition, and finances of medical students at the University of Louisville.

Recruitment

The number of applicants to medical schools in the United States reached its lowest ebb in 1954. At that time 14,538 premedical students were competing for 7,576 places in first year classes. Then the tide began to swell and this trend has continued to the present time. For the class entering in 1964, 19,168 premedical students were competing for 8,800 places. Consequently, recruitment of qualified applicants is not a major problem today.

Even so, we attempt to recruit good students for the University of Louisville Medical School by speaking before college premedical groups, by participating in high school career day programs and by offering tours of selected areas of the Medical Center.

The process whereby an applicant is selected for the entering class in medical school is one of the most important as well as one of the most difficult

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functions of the school. Fitness for admission is determined by the applicant's scholastic record at the undergraduate level, recommendations of his college premedical advisory committee, scores on the Medical College Admission Test, recognition of his extracurricular activities, amount of premedical education and impression on personal interview.

The scholastic record of an applicant is the most important single item in his application. This record, semester by semester, tells our Admissions Committee whether or not the applicant can and will do well in medical school. Scores on the MCAT supplement the college record. Premedical advisory committee reports, letters of recommendation and results of the interview all provide information concerning the applicant's personality and motivation toward medicine.

After all the information has been reviewed, the Committee considers each person carefully, and votes. Decision is reached by a majority vote—that is, at least five of the nine members.

Counseling

When a freshman student arrives at the school for Orientation Week, he meets a member of the basic science faculty who acts as his counselor. Each student is assisted in the choice of his elective program by his counselor. He is also encouraged to seek advice from his counselor concerning development of good study habits and adjustment to the emotional and academic stresses of a medical environment.

A basic science faculty member has no more than four students who remain with him during their preclinical years. When a student begins his Junior year, he associates with a member of the clinical faculty who is his counselor during the last two years of formal medical education. Students in any of the four years have easy access to Dean Smith, Associate Dean Brown and myself if they feel that they have special problems which they want to discuss.

Attrition

Student attrition in United States medical schools, in comparison with other types of higher education, is actually quite low. In the ten entering classes of all U. S. medical schools from 1949 through 1958, only 9 per cent failed to receive the M. D. degree. This contrasts with 40 per cent of college entrants who failed to graduate during comparable years; with 43 per cent of nursing school degree candidates, with an estimated 43 per cent of law school entrants, and with approximately 70 per cent of entrants in some foreign medical schools. There is concern over student attrition in our medical schools, however, because the rate is beginning to increase. The increasing rate of attrition has stimulated the Association of American Medical Colleges to conduct an intensive study of the problem based on past student records, on visits to medical schools, on detailed student questionnaires and on personal interviews of medical students with regular and irregular progress. Final results of this study are anticipated soon.

The attrition rate at University of Louisville is lower than the national rate and is showing a downward trend. During the 1961-1962 academic year four freshmen and one senior withdrew in the first semester. By the end of the summer of 1962, five freshmen and one senior had been dropped. Out of a total population of *332* students, eleven were lost that year, an attrition of 3.3 per cent. During the 1964-1965 academic year one freshman and one junior withdrew in the first semester and one freshman was dropped for disciplinary reasons. By the end of the summer of 1965 one freshman and one junior had been dropped. Hence out of a student population of 353, five students were lost, an attrition of 1.4 per cent.

Finances

The high cost of a good medical education is one of the chief obstacles in attracting qualified persons to the profession of medicine today. Total costs, both school and personal, will vary widely among institutions in the United States. A survey conducted by the Association of American Medical Colleges revealed that *average* annual expenses are as follows: unmarried student, $2,710; married student (no children), $4,790.

The AMA loan program and Government loan programs are the major sources of funds available to medical students. At the University of Louisville a vigorous and expanding scholarship program has provided much assistance in the form of non-refundable grants.

During the 1962-1963 academic year University of Louisville medical students borrowed $69,900 from AMA program and $46,600 from the Federal Government and were given scholarships amounting to $27,925. Last year (1964-1965) students borrowed $47,500 from AMA, and $81,500 from the Federal Government, and received scholarships amounting to $44,575.

We wish to take this occasion to express our deep appreciation to the Alumni of the Medical School whose generosity has made our present scholarship situation possible. We also thank the Jefferson County Medical Society Foundation for their active and increasing support of our scholarship program.

EDITORIALS

Where Were You During the Primary?

IT IS probably not inaccurate to say that many of the physicians in Kentucky pay scant attention to what goes on in the Kentucky General Assembly. The reasons most often given for this lack of interest are that the individual physician is too busy with his medical work or that state political activities hold little interest for the physician.

More than one thousand bills and resolutions were introduced in the 1966 session of the Kentucky General Assembly and over ten percent had health or medical implications. Many of the bills having to do with health and medical affairs had not been discussed with representatives of organized medicine or individual physicians prior to their introduction. This would seem to indicate that the channel of communication between the medical profession and the individual state legislator is not always as good as it might be.

It is generally agreed that the KMA Legislative Key Man System is a good system and was fairly successful in the last Assembly. However, it probably is a fact that not enough members of the state legislature have as a close friend a physician who has worked for his election. The legislator would naturally turn to such a physician for advice regarding health and medical legislation. It is a natural thing to give closer attention to the views of our friends and this would seem to be particularly so if the friend helped in the process of election to the desired office. Viewing this whole matter from the standpoint of the legislator this help at election time should be comprehensive. If a man is to have a successful election campaign he needs those who are willing to work in the campaign in addition to making contributions.

When a physician approaches a state legislator asking for his favorable attention to a certain bill the legislator might well ask him: "Where were you last May when I was running in the primary?" If physicians wait until the General Assembly convenes to contact their lawmakers, it is too late to join the category of helpful friends to the members of the assembly. Once the Assembly begins it seems reasonable that a legislator will be more interested in the opinions of the helpful friends rather than those who are sometimes critical.

One of the difficulties the medical profession encounters even on the state level is that it does not always present a unified political stand. Individual physicians and specialty groups sometimes act on their own without clearing it with the KMA legislative council. It is apparent that this sort of thing does create confusion in the minds of the legislators and reduces the effectiveness of our total legislative effort. It would be better if all proposed legislation in the health field was first cleared through the proper KMA channels.

Kentucky physicians are honored in having Mitchel Denham, M. D., Maysville, as a member of the State House of Representatives. All who have had any contact with the recent General Assembly testify to his effectiveness and his help in securing the enactment of legislation in the public interest. It would be a good thing for the citizens of the commonwealth if we had other physicians of this caliber in the State House of Representatives and the State Senate.

Kentucky physicians are grateful to J. Campbell Cantrill, M. D., Georgetown, Chairman for State Affairs of the Council on Legislative Activities, who spent a great amount of time in Frankfort during this last Assembly meeting and who worked hard and effectively representing the views of the medical profession.

It is desirable that with experience Kentucky physicians will become increasingly effective in legislative activites on the state level. There is no group that should be better informed as to what is best for the citizens of the state in the medical and health field. The final test for any medical or health legislation will be as to whether it is in the best interest of the people who live in Kentucky.

WALTER S. COE, M.D.

To Those Who Go

IT WOULD seem that with 2700 doctors in the state the loss of 55 or 60 young men to the armed services in one year would not cause a serious impact in medical practice. In fact, however, the reverse is true. These men are drawn from our hospital services and many of them from large practices. Their loss from resident and fellowship training means a curtailment of essential work in the hospitals with fewer than the normal complement of men to absorb their duties. The teaching staffs of our medical schools, already limited, will need to cover for these vacancies. Small towns and rural communities from which practitioners are drawn will suffer most because their colleagues who are left, already overburdened with work, will be called upon to supply for the men who are away. Even in our cities where there is supposed to be an ample supply of physicians their loss will be felt appreciably.

Increasing thousands of our men are being called into service. They will undergo a period of military training in preparation for foreign duty which will in many instances tax their physical strength and endurance. They deserve the best of medical care and it is appropriate that a sufficient number of young and capable physicians should be called to administer to them during this emergency. The civilian population, as in all periods of war, must sacrifice their own comforts and security in some measure for the protection of our men in uniform. It is a great consolation to us to know that the young physicians selected for military service are physically able, well trained and endowed with the love of country which will stimulate them to give their very best to the men in service.

For the physician called to military duty there is real sacrifice. There is prolonged absence from his home and family. There is a significant financial loss and some delay of advancement in his chosen field. These, however, have never been regarded as sacrifices too great to make for our national welfare.

There are few physicians who have spent a part of their professional life in military service who do not feel that this has been a stimulating and broadening factor in their medical careers; the men who go now will be no exception. When they return to their respective spheres of activity, they will come with a sense of pride of accomplishment, with the esteem and gratitude of the public, and their achievements in civilian life will be greatly enhanced by their military service. Their assignments will then be filled by younger men who will repeat the same experience.

We must feel a sense of thankfulness that we are able to provide the needed medical care for our military services and we bid these young man temporary adieu and God speed in their new activity. We are at war, and the inconveniences and sacrifices of war are inevitable. We who remain at home will work a little harder and a little longer each day that the quality of civilian medical care will not be seriously curtailed by the loss of those who have been called to serve; and we will do it in the same patriotic spirit as those who go.

SAM A. OVERSTREET, M.D.

Have You Done Your Share?

YOUR AMA-ERF is four years old. It is a very young Foundation which has much to be proud of—and a glance at its record reveals the important activities.

In its brief history, the Foundation:

- transmitted more than $1 million a year from physicians and their wives in unrestricted funds to medical schools;
- guided more than $3 million from physicians and industry into $30 million in loans for medical students, interns and residents;
- created the mechanism that channels funds into research on smoking and health;
- supported the Summer Institute for Medical Journalism which aims at increasing the writing and editing abilities of young physicians;
- established a program in bequests to medical research—a service to bankers and lawyers in guiding their clients' bequests;
- set up the mechanism to accept small contributions to research that by themselves would purchase little, but which when pooled become capable of sponsoring research projects, and
- in the last year has built and opened the Institute for Biomedical Research—an exciting venture in basic biomedical research.

Physically the Institute has space and laboratory equipment in the new addition to the AMA headquarters building. The Institute is designed to provide maximum opportunity for outstanding scientists to devote their full energies to basic research in cellular biology without the distractions of teaching or performing administrative chores. The facility is supported entirely by private funds.

There are already five scientists at work in the Institute, and several more are expected to join them in the near future. Eventually about 25 scientists will be accommodated.

What is ahead for the Foundation? That depends on you. The success of these programs is in the hands of those physicians who endorse them—intellectually and financially. Where do you stand in the fourth year with your Foundation? This is the Foundation which solicits your $100 contributions each year. You may earmark your contributions for the school of your choice. Have you made your contribution?

AMA-ERF COMMITTEE



ORGANIZATION SECTION

Dr. Judd to Address KMA Members At 1966 President's Luncheon

Walter H. Judd, M.D., Washington, D.C., former Minnesota Congressman and a current member of the American Medical Association's Judicial Council, will give the main address at the September 21 President's Luncheon held during the KMA Annual Meeting in Louisville.



Doctor Judd

Everett H. Baker, M.D., Louisville, KMA president announced Doctor Judd's acceptance of his invitation to speak at the luncheon in the Terrace Room at the Kentucky Hotel. His topic will be "Can the Best be Better?"

Doctor Judd, who served ten terms as a representative from Minnesota's Fifth Congressional District, was a medical missionary in China for 10 years. He received his medical degree in 1923 from the University of Nebraska, and received that institution's Distinguished Service Award in 1945.

He is also a recipient of the CARE-MEDICO World Humanitarian Award and the U.S. Chamber of Commerce Great Living American Award. He is the holder of honorary doctorate degrees from 20 colleges and universities. Doctor Judd gave the keynote address at the Republican National Convention in Chicago in 1960.

MEDICARE REGULATIONS INCOMPLETE

With the passage of the act expanding our social security laws to provide hospital and medical care coverage for our over-65 population, your editors immediately began to plan a special section of The Journal describing the implementation of Parts A and B of Title XVIII of Public Law 89-97. This special supplement had been scheduled for this issue.

The complexities in implementing this act, which are being faced by the Social Security Administration, its carriers and providers under both Parts A and B, have proved so difficult to solve that it has not been possible to write regulations covering both Parts A and B at the time we reached our deadline. Both carriers, Blue Cross under Part A and Metropolitan Life Insurance Company under Part B, have given The Journal wholehearted cooperation in this effort but the carriers feel that an statement we could make at this time would not be complete. The Journal does plan to provide this service to you as soon as final regulations are available.



Doctor Weber



Doctor Moore

Color Television to High Light Annual Meeting Sept. 20-22

A wide range of medical topics covered by sixteen prominent guest medical authorities and highlighted by closed circuit color television presentations, will be featured at the intensive postgraduate program offered to Kentucky physicians at the 1966 KMA Annual Meeting at the Convention Center in Louisville September 20-22.

Everett H. Baker, M.D., KMA president and chairman of the Council on Scientific Assembly, who released further details of the program, said that "the Council and its Scientific Program Committee have taken great care to ensure that the program will be one of the finest ever presented by KMA". Roderick Macdonald, Jr., MD., Louisville, is chairman of the Program Committee.

Doctor Baker announced that there will be four-and-a-half hours of color television, presented by Smith Kline and French Laboratories in conjunction with the general sessions, which will originate at the University of Louisville Medical Center. Participants on the television panels will include local and guest speakers.

The KMA president also released information on three out-of-state speakers who will take part in the general scientific sessions as the guests of various specialty groups. Additional speakers will be listed in later issues of *The Journal.*

Robert W. Weber, M.D., Salina, Kans., the guest of the Kentucky Academy of General Practice, will speak on "Antibiotic Complications" at the Thursday, September 22, morning general session. That afternoon he will speak before his host group on a topic not yet announced. Doctor Weber is an assistant clinical professor of medicine at the University of Kansas.

He formerly was assistant professor of medicine

(Continued on next page)

and microbiology at the University of Kansas from 1957-1961. After his graduation from the same school, he completed his internship at the University of Wisconsin and returned to Kansas for postgraduate training. He is a fellow of the American College of Physicians.

Willis E. Brown, M.D., professor and head of the department of obstetrics and gynecology at the University of Arkansas Medical Center, Little Rock, will be the guest of the Kentucky Obstetrical and Gynecological Society and will discuss "Premature Rupture of the Membranes and Effect on the Fetus" at the First General Session Monday morning, September 20.



Doctor Brown

Doctor Brown's topic at the meeting of the Ob-Gyn Society that afternoon has not been announced. A former faculty member at the Universities of Michigan, Nebraska and Iowa, he received his medical degree from the University of Michigan in 1939. He is a former member of the executive board of the American College of Obstetricians and Gynecologists.

George E. Moore, M.D., director and chief of surgery at Roswell Park Memorial Institute at Buffalo, N.Y.. will be the guest of the Kentucky Chapter, American College of Surgeons. His topic at the Thursday morning general scientific session will be "Anticancer Agents". No topic has been announced for the specialty session that afternoon.

Doctor Moore, who also serves as research professor of biology and director of the Roswell Park Division of the graduate school of the State University of New York, was graduated in 1947 from the University of Minnesota School of Medicine, where he received his Ph.D. in surgery in 1950.

Nation's Physician Population To Reach Record High In '66

A record high of 300,000 physicians in the United States will be reached this year when medical schools graduate their 1966 classes. Kentucky's contribution of more than 150 new physicians will come from the medical schools at the University of Louisville and the University of Kentucky.

The Council on Medical Education of the American Medical Association predicts that by 1975 there will be one physician for every 638 people, and by 1985 that ratio will have improved still further to one physician for every 619 people.

In addition to the construction of many new schools in recent years, there has been an expansion of student capacity of the older schools. The AMA has long urged more public and private financing of medical school expansion and construction, according to the Council.



Doctor Maddox



Doctor Bryan

Dr. Bryan Named President-Elect Of KAGP; Dr. Maddox Honored

Thornton E. Bryan M.D,. Cadiz, was named president-elect of the Kentucky Academy of General Practice, and Paul F. Maddox, M.D., Campton, received the "Doctor-Citizen of the Year" award during the KAGP's annual business and scientific assembly May 10-15 in Louisville.

Doctor Bryan will succeed Robert M. Sirkle, M.D., Lexington, who took office during the same meeting.

The new president-elect, a native of Frankfort, received his B.S. degree in 1949 from the University of Kentucky, and was graduated from the University of Louisville School of Medicine in 1954. Following an internship at Philadelphia General Hospital, he went to Cadiz in 1955.

Doctor Bryan, who is president of the Trigg County Medical Society, has served as a vice-president of the KAGP, and was a member of the Board of Directors when elected to his new office. He is president of the Trigg County Tuberculosis and Respiratory Disease Association and president of the local Rotary Club.

Doctor Maddox who has been called the busiest physician in the country, is the only one in Campton and Wolfe County, where he has practiced since 1953. He was graduated in 1952 from the University of Louisville School of medicine and interned at Good Samaritan Hospital in Lexington.

He is chairman of the Board of Bethany Children's Home at Bethany, a member of the Board of Hazel Green Academy, former president of the Wolfe County Kiwanis Club, and is active in religious and political work. He has served three times as mayor of Campton.

A total of 330 physicians registered for the meeting at the Kentucky Hotel, breaking the previous record attendance.

TVMA to Meet in September

The annual meeting of the Tennessee Valley Medical Assembly has been scheduled for September 26-27 at the Tivoli Theater, Chattanooga. Further information may be obtained by writing to William Robert Fowler, M D., Chairman, 109 Medical Arts Building, Chattanooga, Tenn. 37402.

Dr. Edelen Elected President Of Ky. Surgical Society

Charles M. Edelen, M.D., Louisville, was elected president of the Kentucky Surgical Society at its May 13-14 meeting at French Lick, Ind. He succeeds Rudolf J. Noer, M.D., Louisville.

Blaine Lewis, M.D., Louisville, Society secretary, reported that nearly 100 physicians and their guests were registered for the meeting, which was regarded among the best the group has held.

Other officers elected during the business meeting were Richard Weddle, M.D., Somerset, vice-president; and Delmas M. Clardy, M.D., Hopkinsville, chairman of the Council. Doctor Lewis is to continue in office for two more years.

The limited-membership organization elected two new members, Charles B. Wilson, M.D., Lexington, and Joseph E. Kutz, M.D., Louisville, bringing the total membership to 125.

Angus D. McLachlin, M.D., professor and chairman of the department of surgery at the University of Western Ontario, London, Ont., was the main guest speaker on the scientific program, which included the presentation of 16 papers.

Next year's meeting has been tentatively scheduled for Park Mammoth Resort.

Rural Scholarship Loans Awarded; Board Creates New Loan Plan

Eleven new loans and more than 20 renewal loans were granted by the Rural Kentucky Medical Scholarship Fund Board of Trustees at its May 18 meeting in Louisville, according to C. C. Howard, M.D., Glasgow, chairman of the Fund's Executive Committee.

Doctor Howard also announced the inauguration of a new program designed to encourage young physicians to enter practice in areas of the state critically in need of their services. The Board meeting marked the 20th anniversary of the establishment of the Fund and of Doctor Howard's chairmanship.

The new phase of the Scholarship plan involves the loan of $1,000 to a physician entering practice to establish his office in one of ten counties designated as "semi-critical". These loans are to be differentiated from those for $2,000 going toward the establishment of practice in one of the ten "critical" counties.

Critical counties are: Carter, Crittenden, Knott, Lewis, Magoffin, Martin, Metcalfe, Powell, Rockcastle and Wolfe. The newly-designated "semi-critical" counties are: Breathitt, Butler, Clay, Estill, Jackson, Leslie, Lincoln, Meade, Owen and Owsley. Counties are selected on the basis of information supplied by KMA and the State Board of Health.

The $2,000 loans are forgiven in amounts of $500 per year for each year of practice in a critical county. The $1,000 loans are forgiven in amounts of $250 per year for practice in semi-critical counties.

Of the 11 new loans awarded at the Board meeting, seven were for $2,000 to students agreeing to practice in critical counties on completion of their training. This is an increase from one such loan awarded last year. Four regular first loans of $1,300 were awarded, to be repaid at a rate of 2% interest to maturity, when the rate increases to 6%. Five loans are pending approval.

Of the total of 280 loans granted since the inception of the Fund, 129 recipients are now in practice in 80 of Kentucky's 120 counties, Doctor Howard reported. Eight are located in critical counties.

During the meeting the chairman expressed his appreciation to Kentucky Governor Edward T. Breathitt, Health Commissioner Russell E. Teague, M.D., and the General Assembly for their continued support of the Rural Medical Scholarship Fund program.

Pratt Named President-Elect Of Ky. Hospital Assn.

John C. Pratt, administrator of Good Samaritan Hospital in Lexington, was chosen president-elect of the Kentucky Hospital Association during the April 25-28 annual convention in Louisville.



Mr. Pratt

He will take office in 1967, succeeding Randall C. Eli, Ashland, who was installed at the April meeting.

A native of Duluth, Mr. Pratt received his bachelor's degree in business administration and his master's in hospital administration from the University of Minnesota. He was formerly associated with Harper Hospital in Detroit and Flower Hospital in Toledo, and went to Lexington from the Bronson Methodist Hospital in Kalamazoo.

Approximately 1,470 registered for the annual session, held at the Kentucky Hotel.



George A. Sehlinger, M.D., center, Louisville, chairman of KMA Council on Medical Education and Hospitals, presents checks to William R. Willard, M.D., left, Dean of the U. of K. College of Medicine and Donn L. Smith, M.D., right, Dean of the U. of L. School of Medicine. The checks were for $4,178.18 and $8,981.02, to the U. of K. and the U. of L., respectively.


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D. Lane Tynes, Blue Cross Head, Receives Hospital Assn. Award

D. Lane Tynes, Louisville, president of Blue Cross Hospital Plan, Inc., and executive director of Kentucky Physicians Mutual, Inc., received the Kentucky Hospital Association's Distinguished Service Award on April 26 at the KHA President's Luncheon during its annual meeting in Louisville.



Mr. Tynes

The award was given to Mr. Tynes in recognition of his contribution in the establishment of the Blue Cross prepayment plan in Kentucky. He is also a past recipient of the Kentucky Medical Association's R. Haynes Barr Award given to the lay person who has contributed most to medicine and health programs in the state.

Blue Cross, then called the "Community Hospital Service", was founded in 1938 under Mr. Tynes' direction. He came to Louisville from Ashland, where he had headed a similar prepayment plan. He is a native Texan and a graduate of the University of Texas, and former all American football player.

Interim Meeting Events

(See Opposite Page)

1. KMA WOMAN'S AUXILIARY officers met during the KMA Interim Meeting at DuPont Lodge, Cumberland Falls, April 13-14 to discuss plans for the coming year. From left to right are Mrs. Earl Roles, Louisville, parliamentarian; Mrs. Robert Salisbury, Mt. Sterling, president; Mrs. Raymond Jones, Louisville, president-elect; and Mrs. J. Murray Kinsman, Louisville, past president.

2. AMA PRESIDENT James Z. Appel, M.D., Lancaster, Pa., second from left, presented plaques to three Kentucky physicians in recognition of their volunteer services in Vietnam under the auspices of Project Vietnam and CARE-MEDICO. Receiving the AMA awards are, from left, George F. Brockman, M.D., Greenville; S. Pearson Auerbach, M.D., Louisville, and Charles C. Kissinger, M.D., Henderson.

3. KMA OFFICIALS pose at the Interim Meeting with AMA President James Z. Appel, M.D., center. From left are: George F. Brockman, M.D., Greenville, speaker of the House of Delegates; Hubert C. Jones, M.D., Berea, chairman of the Board of Trustees; Doctor Appel; Robert C. Long, M.D., Louisville, former KMA delegate to the AMA and now a member of the AMA Board of Trustees; and Robert E. Pennington, M.D., London, KMA president-elect. Doctor Appel spoke at the April 14 luncheon session.

4. MEDICARE was the topic of a discussion presented at the meeting of the KMA Board of Trustees April 13 at Cumberland Falls by General Paul I. Robinson, M.D., vice-president and chief medical director of Metropolitan Life Insurance Company of New York, carrier for Kentucky of Part B, Title XVIII, of PL 89-97. With Doctor Robinson, center, are, from left: Everett H. Baker, M.D., Louisville, KMA president; Henry B. Asman, M.D., Louisville, secretary; George W. Pedigo, Jr., M.D., vice-president, who represented medicine's point of view during the discussion; and Robert E. Pennington, M.D., London, president-elect.

NEWS ITEMS

Robert M. Wooldridge, M.D., formerly of Paducah, has opened an office at Grand Rivers, where he will be in general practice. Doctor Wooldridge was graduated in 1949 from the University of Louisville School of Medicine and interned at Nashville General Hospital. He served a year as an anesthesiology resident at Vanderbilt Hospital before going to Paducah.

Richard E. Mardis, M.D., Lousville, was elected president April 22 of the Kentucky TB and RD Association. He succeeds **E. N. Maxwell, M.D.,** also of Louisville, who has been president for the past two years.

David M. Greeley, M.D., formerly medical director of the Daniel Boone Clinic at Harlan, has been named director of medical care and medical facilities planning for the Chicago Board of Health.

T. R. Brandstetter, M.D., has started general practice at Salem, where he is associated with **Roscoe Faulkner, M.D.** Doctor Branstetter, a 1962 graduate of the University of Louisville School of Medicine, interned at the U.S. Naval Hospital in San Diego, and recently completed his military service as a Naval Flight Surgeon.

Murray A. Diamond, M.D., formerly of Lexington, received the U.S. Public Health Service's Meritorious Service Medal on April 7. Now assistant surgeon general in the Public Health Service, Doctor Diamond was medical officer in charge of the USPHS. Hospital in Lexington and associate clinical professor of psychiatry at the University of Kentucky.

Appointed on Reference Committee

As we went o press it was learned that Carroll L. Witten, M.D., Louisville has been appointed to serve on the AMA's reference committee on miscellaneous business during the annual meeting in Chicago, June 27-30.

Dr. Witten, immediate past president of the Kentucky Association of General Practitioners and president of the American Academy of General Practice is a delegate from the AMA's section of general practice.

KMA Membership Grows as 13 New Names are Added to Roll

Thirteen new members joined the KMA recently, according to the membership department. Six of the new members are from Louisville. They include: William D. Caso, M.D.; Bob M. Deweese. M.D.; Sidney G. Marcum, M.D.; Patrick P. O'Connor, M.D.; Robert R. O'Connor, M.D.; and Ronald L. Rogers, M.D.

Also listed were: Okey H. Sanford, Jr., M.D., Ashland; L. B. Craycraft, M.D., and D. H. Donahoe, M.D., Catlettsburg; and William Bauer, M.D., and Dan A. Martin, M.D., Madisonville.

Other new members are: Bohdon Cymbala. M.D., Henderson; M. A. Greenwell, Jr., M.D., Hopkinsville.

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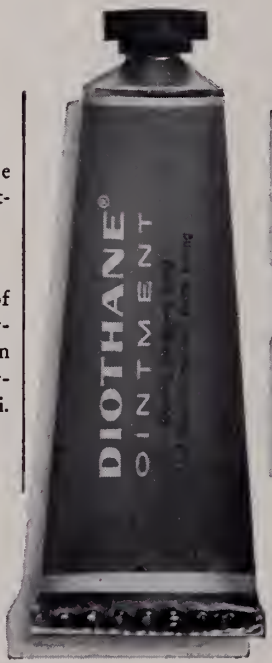
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CHARLES G. BRYANT, M.D., Louisville, center, installed the new officers of the Kentucky State Association of Medical Assistants during the group's annual meeting in Louisville May 14 and 15. Pictured with Doctor Bryant are, from left, Mrs. Jane Burks, vice-president; Mrs. Virginia Applegate, president-elect; Miss Tina Gates, president; Mrs. Hulda Upton, treasurer; Miss Louise Jobe, recording secretary; and Mrs. Donna Willis, corresponding secretary.

Ky. Assn. of Medical Assistants Elects Miss Gates President

At the Fourth Annual Meeting of the Kentucky State Association of Medical Assistants held May 14-15 in Louisville, Miss Tina Gates was installed as president, succeeding Mrs. Wanda Taylor. The Association named Mrs. Virginia Applegate president-elect. All are from Louisville.

Everett H. Baker, M.D., Louisville, KMA president, was the featured speaker at the luncheon on Sunday. George F. Brockman, M.D., Greenville, speaker of the KMA House of Delegates, presented a series of slides on Vietnam at the Saturday afternoon session. Speaker at the banquet on Saturday night was Eugene H. Conner, M.D., Louisville.

Other officers elected at the meeting were: vice-president, Mrs. Jane M. Burks, Elizabethtown; recording secretary, Miss Louise Jobe, Elizabethtown; treasurer, Mrs. Hulda Upton, Louisville; and corresponding secretary, Mrs. Donna Willis, Louisville.

Two awards were given at the meeting. One, for the largest membership percentage increase from January through April 15, was won by the Warren-Barren-Edmonson county group. The other award, given for the largest percentage of membership attendance, went to the Hardin-Larue county group.

AMA to Sponsor Conference On Medical Aspects of Sports

The Eighth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association's Committee on the Medical Aspects of Sports, will be held in Las Vegas at Caesar's Palace on November 27.

Included will be forums and discussion sections relating to criteria for immediate management of knee injuries, resources for grass roots supervision of sports, and many others.

The Conference is open to key nonmedical athletic personnel as well as interested physicians. For further information write to the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 N. Dearborn St., Chicago, Ill., 60610.

State Presidents to Meet June 26

Everett H. Baker, M.D., Louisville, KMA president, will head the list of KMA officers attending the annual Conference of Presidents and Other Officers of State Medical Societies at 9:30 a.m. Sunday, June 26 at the Palmer House in Chicago. Australian Medical Association President Angus Murray, M.D., and former U.S. Vice-President Richard M. Nixon, will be the two featured speakers. The meeting is held in conjunction with the AMA meeting.

Kentucky Physicians Honored on Doctor's Day, March 30

Doctor's Day was observed by many county auxiliaries on March 30. The day set aside each year to honor physicians is the anniversary of the date in 1842 when Crawford W. Long, M.D., first used ether as an anesthetic agent in a surgical operation.

To honor the physicians of Whitley County, the auxiliary sponsored a Health Careers Day, presented each doctor with a red carnation, and put miniature black doctor's bags on patient's trays at Southeastern Kentucky Baptist Hospital.

Members of the Boyd, Carter, and Greenup Medical Auxiliary presented a check honoring physicians of the three counties to the AMA's Education Research Foundation.

Doctor's Day in Barren County was highlighted with a dinner at the Glasgow Country Club where

(Continued on page 524)

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Contact: Medical Director, Highland Hospital, Asheville, N.C. 28801

(Continued from page 522)

each physician was presented with a red carnation. Members of the Bell County Medical Society honored their physicians by putting a red carnation on each doctor's desk at the Appalachian Regional Hospital.

A book entitled, "Doctors to the World" by Morgan was presented to the Fulton Public Library by members of the Fulton County Medical Society to commemorate the day. Physicians also were guests of honor at a dinner at the Park Terrace.

Jefferson County's physicians were honored at a dinner dance at the Executive Inn in Louisville. Somerset and Pulaski County physicians were guests of the Woman's Auxiliary to the Pulaski County Medical Society at the First Christian Church.

Medical School News

Land Purchased, Tuition Raised at U. of L. Med School

Recent developments at the University of Louisville School of Medicine include: purchase of additional land in the medical center, an increase in medical school tuition, and two faculty resignations.

The School's board of trustees approved the purchase of additional land for the medical-dental teaching and research complex at a cost of $760.000. The entire building complex is to cost about $24 million. U of L President said the University needed possession of the land before it could receive some $9 million in federal funds. It recently received a $2.7 million grant. The land is bounded by Walnut, Jackson, and Madison and the existing medical-dental research building, on the west.

Medical school tuition will increase from $1,050 to $1,200 for residents and $1,525 to $1,700 for nonresidents. In the medical school residency status is extended to all residents of Kentucky.

Resignations were accepted from William L. Miller, M.D., as assistant professor of pathology, and Jo Anne Sexton, M.D., as assistant professor of pediatrics.

Special Infant Care Program Set For Nurses, M.D.s, at U. of K.

A specal two-week educational program in the care of premature infants and other newborns who require special care will be offered to Kentucky nurses and physicans at the U. of K. Medical Center July 18-29.

The department of pediatrics and the College of Nursing at the University, in cooperation with the Division of Maternal and Child Health of the State Department of Health, is sponsoring the course for those actively engaged in the care of the newborn.

Nurses will attend the full two weeks; physicians, the last two days. For further information, write to Robert A. Beargie, M.D., Dept. of Pediatrics, University of Kentucky Medical Center, Lexington, Ky. 40506.

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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Second aid for a button popper

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Sustained Release Capsules

By providing combined anorexigenic-tranquilizing action, BAMADEX SEQUELS Capsules help your nonshrinking patients to establish new patterns of eating less. The amphetamine component suppresses the appetite, while the meprobamate helps allay nervousness and tension. And for most patients, the *sustained* release of the active ingredients makes possible convenient one-capsule-a-day dosage.

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Dr. Parr Elected to Berea Board

Eugene Q. Parr M.D., Lexington, was named to the Board of Trustees of Berea College at a meeting of the Board late in April, according to published reports.

A 1946 graduate of Berea, he received his medical degree from the University of Louisville in 1952 and practiced in Berea from 1953 to 1956. Following residency training in orthopedic surgery at Mayo Clinic, Doctor Parr entered practice at Lexington. He is a clinical instructor in orthopedic surgery at the University of Kentucky.

Dr. Fulmer Heads Thoracic Group

Hugh S. Fulmer, M.D., Lexington, was installed as president of the Kentucky Thoracic Society at the group's annual spring business meeting late in April. He succeeds Herbert T. Ransdell, Jr., M.D., Louisville.

Other officers named at the meeting were: E. R. Gernert, M.D., Louisville, president-elect; Joseph H. Humpert, M.D., South Fort Mitchell, secretary-treasurer; and Grover B. Sanders, M.D., Louisville, representative councilor to the American Thoracic Society.

Orthopedic Society Meeting Held

Robert D. Ray, M.D., professor and chairman of orthopaedics, University of Illinois, was the featured speaker at the Spring dinner meeting of the Kentucky Orthopedic Society and the Cincinnati Orthopedic Society at the Springs Motel, Lexington, April 23.

The afternoon program at the University of Kentucky Medical Center consisted of papers presented by physicians and residents from Louisville and Lexington, according to David B. Stevens, M.D., Lexington, president of the Kentucky Orthopaedic Society, who presided.

Blue Cross Promotes Ed McConnell

J. Ed McConnell, Louisville, has been promoted by the Board of Trustees of the Kentucky Blue Cross Plan at its May 16 meeting to the office of executive vice-president. He had been serving as vice-president in charge of external affairs.

Mr. McConnell came with the Kentucky Blue Cross Plan, according to D. Lane Tynes, president of Blue Cross, who made the announcement, in 1941 when he began work at Lexington. Mr. McConnell is also assistant executive director of the Kentucky Blue Shield Plan.

Infant Mortality Conference Set

The AMA National Conference on Infant Mortality has been scheduled for August 12-13 at the Fairmont Hotel in San Francisco, according to Fred V. Hein, Ph.D., secretary of the AMA Committee on Maternal and Child Care.

All chairmen and members of all state and county maternal and child care, perinatal and maternal mortality committees are invited to attend. For further information, write the Secretary, Committee on Maternal and Child Care, American Medical Association, 535 N. Dearborn St., Chicago, Ill., 60610.

Otolaryngology Meeting Scheduled

The department of otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from October 31 through November 12. Interested registrants may write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill., 60680.

KMA Council and Committee Reports

Ky. Advisory Committee to Selective Service

J. Duffy Hancock, M.D., Louisville, Chairman

KMA Headquarters Office **Friday, May 6, 1966**

There have been two recent meetings of the physician members of the Kentucky Advisory Committee to Selective Service with Colonel Everette Stephenson and members of his staff.

The committee met on March 22 at the State Selective Service Headquarters office in Frankfort, and again on May 6 at the KMA Headquarters office.

At both meetings, Kentucky physicians whose classifications have been changed from 2A to 1A were considered in depth. In order to maintain a balance in distribution to take care of the civilian population, some were necessarily left in 2A.

In other areas where coverage seemed more adequate, it was considered imperative to reclassify some of the physicians.

KMA Technical Advisory Committee on Indigent Medical Care

C. C. Waldrop, M.D., Williamstown, Chairman

KMA Headquarters Office **Monday, April 11, 1966**

The KMA Technical Advisory Committee on Indigent Medical Care met on April 11, 1966, to

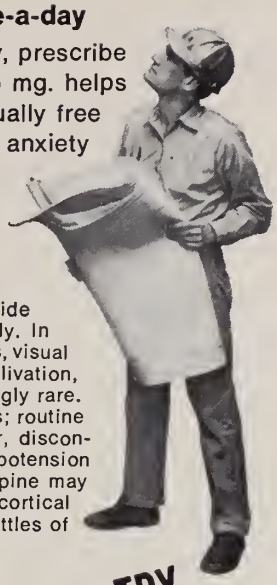
(Continued on page 529)

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Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

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SQUIBB FLUPHENAZINE HYDROCHLORIDE

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- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
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Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
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(Continued from page 526)

formulate a proposal for physicians' services under the Kentucky Public Assistance Program for implementation of Title XIX of PL 89-97, the "Medicare Act".

A recommendation was made and presented to the KMA Board of Trustees at its Interim Meeting at Cumberland Falls on April 12-13, incorporating the use of relative value units for the reimbursement of physicians' services under this program.

Guests in attendance at this meeting included William H. McBeath, M.D., M.P.H., Director, Division of Medical Care, and two assistants.

Cancer Coordinating Committee

Condict Moore, M.D., Louisville, Chairman

KMA Headquarters **April 18, 1966**

The Cancer Coordinating Committee recently held its second meeting of the year at the State Health Department in Frankfort. Also attending the meeting were Russell Teague, M.D., commissioner of health, and other state Health Department officials.

A detailed explanation was given by health department officials on their proposed plan for a statewide cervical cancer program. Considerable discussion was held with committee members suggesting changes in the program as outlined.

Members of the committee also recommended through proper KMA channels that a pathologist and a radiologist be appointed to the committee to represent their respective specialty groups.

Industrial Medicine Committee

Walter L. O'Nan, M.D., Henderson, Chairman

KMA Headquarters Office **April 20, 1966**

Members of the Industrial Medicine Committee met recently at KMA Headquarters Office for the second time this associational year. A comprehensive report was made on the recently-held Governor's Occupational Health Conference and a recommendation was made that KMA continue to be a sponsor.

Several other items pertaining to health matters in industry were thoroughly discussed with recommendations made to the KMA Board of Trustees.

Members also prepared the committee's final report o be presented to the House of Delegates in September.

Tuberculosis Committee

Joseph Humpert, M.D., Mitchell, Chairman

KMA Headquarters Office **April 17, 1966**

The KMA Tuberculosis Committee met recently in the Headquarters office and discussed in detail the TB Eradication Program under way in the state. It was reported that the testing program among school children is being well received and since September 1964. the beginning of the program, 137,000 children and school personnel have been tested. The program to date has found 23 cases of active infectious tuberculosis and 32 cases of primary tuberculosis.

(Continued on page 532)

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Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

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Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be virtually free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

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1966 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 20, 21, 22**

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BENJAMIN B. JACKSON, M.D., Chairman

Committee on Scientific Exhibits

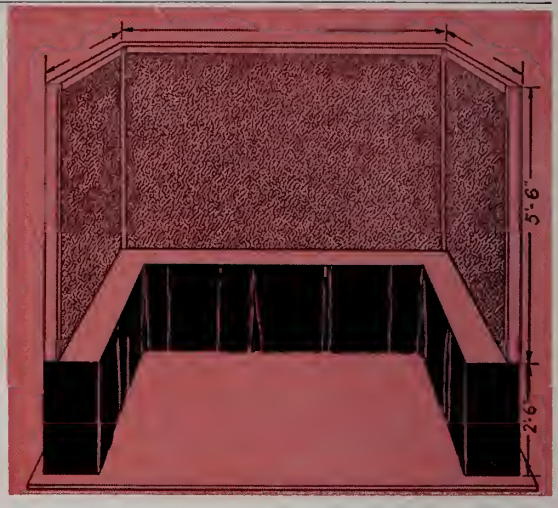
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1966

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....
   .....
   Institution (if desired): .....
   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings .... X-rays....
   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
   Amount of wall space needed? .....
   Back wall .....Side walls (All side walls are 4') .....
   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Mead Johnson Aesculapius Award of $200.00 and identifying plaque will be presented by the KMA for the best exhibit in 1966.

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

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Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

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(Continued from page 529)

Committee members received a report on the Second Campbell House Conference held in Lexington last November. A specific recommendation came out of the conference urging the Governor to form a committee to develop a more enthusiastic attack on TB control.

Reports also were given by Thomas Summer, Executive Director, Kentucky TB and RD Association; Stuart Lauder, M.D., C.M., Director of TB Control, Department of Health, Frankfort; and Thomas Layton, Executive Director of the State TB Hospital Commission, Frankfort, on TB activities in their particular organizations.

Members of the committee also made two specific recommendations to the KMA House of Delegates, to be considered in September 1966—the first concerning the school tuberculin testing program instigated by the American School Health Association, and the second requiring nursing homes to have chest x-rays made on all initial admission patients as a requirement for certification for accreditation by the State Board of Health.

Physical Medicine and Rehabilitation

W. K. Massie, Jr., M.D., Lexington, Chairman

The KMA Committee on Physical Medicine and Rehabilitation met recently at the Headquarters office and discussed in detail purposed changes in the Workmen's Compensation Law.

Committee members continued its interest in rehabilitation re-training, re-employment, and relocation of the physically impaired individual. Plans were formulated to publish in the KMA Journal a list of available facilities for rehabilitation and available schools for re-training in the varied rehabilitation programs.

The committee set June 2, 1966, as its next meeting date at which time it will prepare its final report to the House of Delegates.

Dental-Nurse-Pharmacy Committee

Melvin J. Weber, M.D., Ludlow, Chairman

KMA Headquarters Office **April 21, 1966**

Members of the Pharmaceutical Association met recently with the KMA Dental-Nurse-Pharmacy Committee at the Headquarters office to discuss mutual problems of their respective groups.

Among the many items to receive a thorough discussion included straight lines to doctors offices, forged prescriptions, doctors quoting prices, cautioning patients of dangerous drugs, and putting name of drug on the label. It was noted that KMA had already acted on recommendations made last year by the joint meeting of the two groups on these items, but the Pharmaceutical Association's governing body had not taken action to date.

Members discussed the new pharmacy law recently enacted by the state legislature and the new drug abuse control law passed by the U. S. Congress. Plans for the committee's final report to the House of Delegates also were formulated.

Committee on Medicine and Religion

Joseph H. Saunders, M.D., Lexington, Chairman

KMA Headquarters Office **Wednesday, May 4, 1966**

The Committee on Medicine and Religion met on May 4, 1966, to review accomplishments and to discuss future plans for the year. This meeting was attended by Arne Larson, assistant director of the Department of Medicine and Religion of the AMA.

Mr. Larson presented a number of periodicals available for use in the planning of programs on this subject. The committee has plans for a booth at the 1966 KMA Annual Meeting, and it is requested that all physicians visit this exhibit.

The next meeting of the committee will be a breakfast session during the Annual Meeting.

School Health Committee

O. B. Murphy, M.D., Lexington, Chairman

KMA Headquarters Office **May 11, 1966**

Members of the KMA School Health Committee met at the Headquarters Office and continued their discussion on establishing a better physical education program in the state's school system. It was agreed that progress is being made in this area and that this project be one of the main areas of concentration for the committee's future activities.

The committee reviewed results of the School Health Exhibit, "Health Appraisal of the school Child," which was displayed at the KEA Annual Convention. It was felt that the exhibit served a useful purpose but in the future more attractive and attention-getting exhibits should be on display.

Members discussed the committee's efforts to develop a good liaison between the KMA School Health Committee and local county society School Health chairmen and developed a list of pamphlets which are to be sent to these county chairmen in the event they are called upon to appear before any groups to speak on matters of school health. The committee also recommended to the Board of Trustees through the Council on Communications and Public Service that another county chairman meeting be held during the KMA Annual Meeting in September.

Committee on Aging

Earl P. Oliver, M.D., Scottsville, Chairman

KMA Headquarters Office **April 26, 1966**

Members of the Aging Committee met at the KMA Headquarters Office recently and concentrated its efforts on PL 89-97 as it would affect the aged citizen. A report was given on the Kentucky Commission on Aging and its current activities. It was noted that the activities of the commission had been decreasing in the past year due to lack of support, and it was recommended that the KMA approach the proper state agency and stress that more active support be forthcoming for the commission.

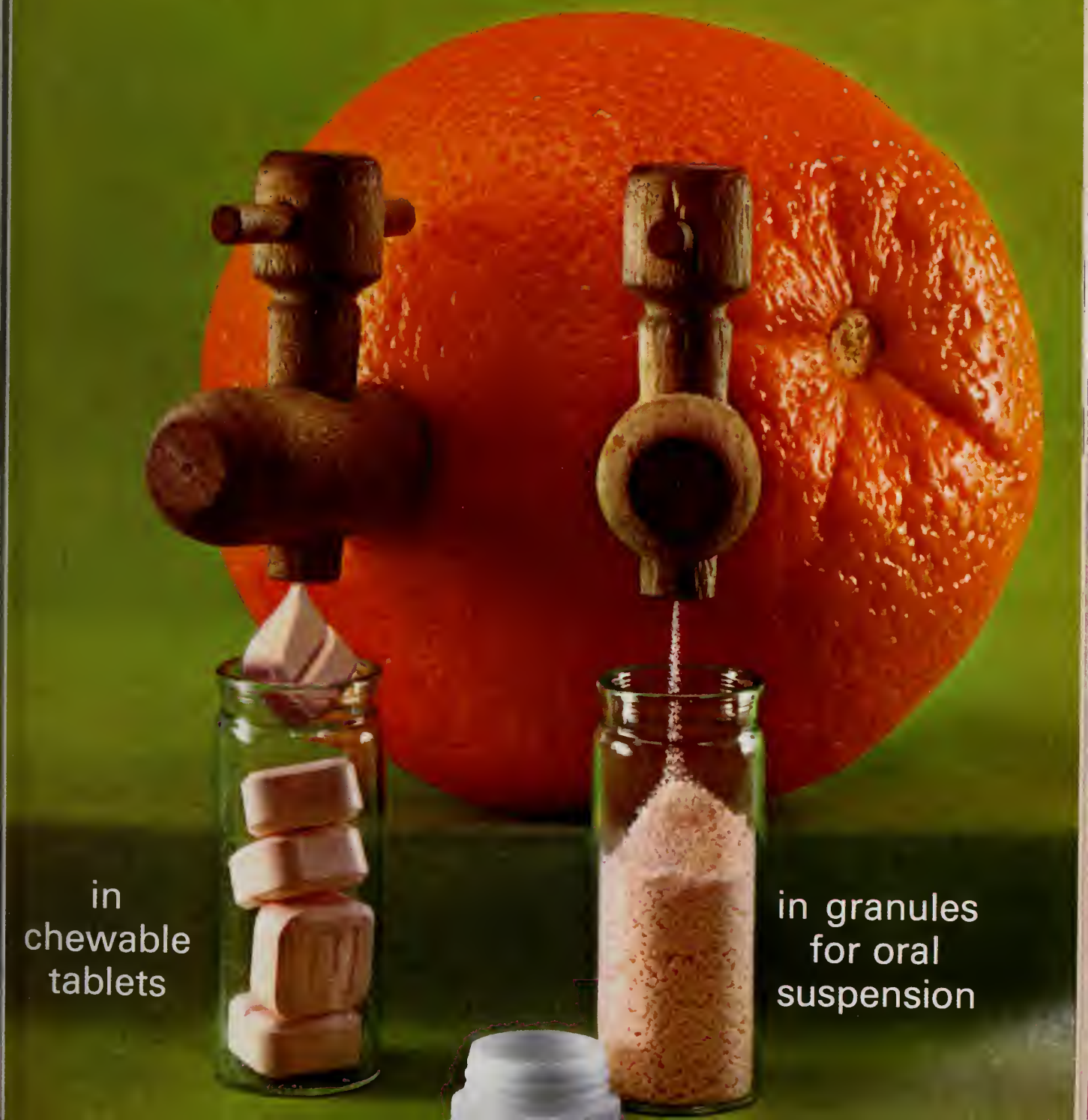
The committee made several recommendations to be included in its final report to the House of Delegates.

(Continued on page 535)

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The rationale: When combined, Erythrocin and the trisulfapyrimidines (triple sulfas) are indicated in infections that are more susceptible to the combination than to either agent alone. Such conditions are usually found in urinary, lower respiratory tract and chronic ear conditions.

The results: Clinical studies involving 142 young patients showed *an overall cure rate of 96.5%*. Side effects were experienced by only four of the patients.

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Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

ABBOTT

KMA Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman, National Affairs; J. Campbell Cantrill, M.D., Georgetown, Chairman, State Affairs

KMA Headquarters Office **Wednesday, April 5, 1966**

A report from the chairman for State Affairs, J. Campbell Cantrill, M.D., of the 1966 Kentucky General Assembly was presented to the Council for its consideration at its meeting on April 6, 1966. This final report was approved and referred to the KMA Board of Trustees for information.

John C. Quertermous, M.D., chairman for National Affairs, discussed the proposed legislation now being considered in the second session of the 89th U. S. Congress, which included "Preventicare", an expansion of the "Medicare Act" and the numerous bills relating to the transporting and care of laboratory animals used in research centers.

The council expressed concern over the policies of the HEW encouraging the use of "generic equivalent" drugs and recommended that the ultimate choice of the drugs prescribed should remain with the individual physician in all public assistance programs under "Medicare".

COUNTY SOCIETY REPORTS

McCracken

The regular monthly meeting of the McCracken County Medical Society was held at Boswell's Restaurant on April 27.

Rodney Fields, M.D., Memphis neurosurgeon, presented the scientific program. He discussed "The Management and Classification of Acute Head Injuries", illustrating his talk with x-ray film slides.

Following the scientific program, the business meeting was called to order by Walter Johnson, M.D., Paducah, Society president. After hearing two committee reports, there was a discussion of the participation of the Society in setting up Utilization Review Committees for the evaluation of the hospital care and hospital stay of Medicare patients. Most members felt that this was a function of the various hospital staffs, and not of the medical society.

The president then requested the secretary to collect as much material as possible regarding alternatives open to physicians in being reimbursed by patients under Medicare.

The meeting adjourned at 8:20 p.m.

Following is a list of recently reported county medical society officers. Others will be listed in July.

Barren

President, C. B. Foster, Jr., M.D.; secretary-treasurer, Lewis Dickinson, M.D.; delegate, E. L. Marion, M.D.; alternate, W. H. Bryant, M.D. All are from Glasgow.

Breckinridge

President, Carroll F. James, M.D., Hardinsburg; Vice-president, Harold Owens, M.D., Irvington; secretary-treasurer, William J. Cates, M.D., Cloverport;

(Continued on page 538)

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut o home remedies without success, pleasant-tastin CREMOMYCIN can answer the call for help. It can b counted on to consolidate fluid stools, soothe intes tinal inflammation, inhibit enteric pathogens, an detoxify putrefactive materials — usually within few hours.

CREMOMYCIN combines the bacteriostatic agents succinylsulfathiazole and neomycin, with the ad sorbent and protective demulcents, kaolin and pec tin, for comprehensive control of diarrhea.

INDICATIONS: Diarrhea.

CONTRAINDICATIONS: Do not use in intestinal obstruction, e tensive ulceration of bowel, or diverticulosis; in hypersensitivi to sulfonamides or neomycin; in pregnancy at term, in prematu infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients wi hepatic or renal damage, urinary obstruction, or blood dyscr sias. Fatal hypersensitivity reactions and blood dyscrasias r ported with use of sulfonamides. Consider periodic blood count hepatic and renal function tests during intermittent or chron use.

PRECAUTIONS: Succinylsulfathiazole: Use with caution if the is history of significant allergies and/or asthma. Continued us requires supplementary vitamins B_1 and K. *Neomycin:* Watch f

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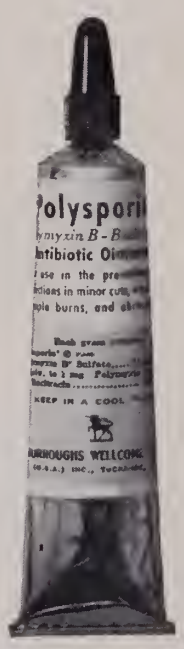
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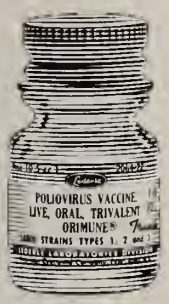
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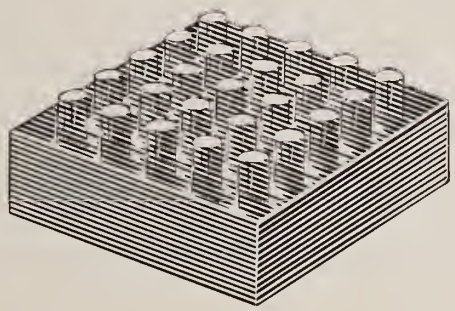


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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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In Memoriam

CHARLES F. WOOD, M.D.
Louisville, Ky.
1908-1966

Charles F. Wood, M.D., 57, an orthopedic surgeon, died April 29 of a heart attack while playing golf. Doctor Wood, who received his medical degree in 1934 from University of Louisville Medical School, was a former president of Kentucky Orthopedic Society, and a member of the boards of several Louisville hospitals. He also was a member of several national medical organizations and was a vestryman at Calvary Episcopal Church.

LYTLE ATHERTON, M.D.
Louisville, Ky.
1893-1966

Lytle Atherton, M.D., 72, an urologic surgeon, died May 8 at a Louisville hospital. Having graduated from the University of Louisville Medical School in 1917, he served as an assistant professor emeritus in urology there. Doctor Atherton was a founder and a director of the Lincoln Income Life Insurance Company. He was a former president of the Louisville Surgical Society and a member of the Kentucky Surgical Society.

ROBERT C. SIEVERS, M.D.
Somerset, Ky.
1883 - 1966

Robert C. Sievers, M.D., 82, a general practitioner and a 1908 graduate of the Hospital College of Medicine at Louisville, died March 5 at Somerset after a short illness. Doctor Sievers, an emeritus member of KMA, was active in civic, religious, and fraternal affairs in his community.

Antigenic Observations

(Continued from page 506)

Though Coccidioidomycosis (primary infection) is common in scattered arid and semi-arid areas of this country, the incidence found was not deemed out of proportion to that of the national average, but the distribution of 12 negro and 6 whites is considered unique in that one would expect the positive reactors to occur 10 times more often in dark-skinned races than in the Caucasian.[2]

Histoplasmosis infection is extremely common, occurring sometimes in as much as 80% of the population in wide areas of the Americas.[3] The incidence of 17.8% of histoplasmin positive reactors may therefore be considered low. Of interest to note is that 96% of those who are positive reactors to histoplasmin had at some time in their lives been associated with the raising of poultry where they would naturally have had an excellent opportunity for exposure to air-borne spores.

Blastomycosis is a sporadically occurring disease entirely, and though two-thirds of patients are between 15 and 45 years of age,[4] no positive reactors were found among the student population tested.

Summary

Job Corpsmen are selected from the lower social-economic strata of our society. Of the more common granulomatous diseases for which they were antigenically tested, it was found that the incidence of tuberculosis is slightly higher than that which one would expect from the population at large.

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4. Ibid, page 58

Carcinoma of the Cervix

(Continued from page 505)

strong family ties. While their home may be a simple shanty "up the creek", many of these women would rather die there, than to be away for the time required to undergo adequate therapy.

What is the solution to the problem of late diagnosis of cervical cancer? A workable large scale cytology screening program is essential for the eradication of cervical cancer. Ideally, such a program should be carried out by local physicians. In areas where insufficient physicians are available, screening centers seem advisable. Facilities for interpretation of the smears so obtained are available in centers throughout the area, and should be expanded if necessary. Before a program such as this can succeed, however, a mass effort at patient education will be required. Recruitment of personnel for this latter effort through local medical societies, service groups and churches would seem reasonable.

Summary

Two hundred forty-six patients with carcinoma of the cervix seen at the University of Kentucky Medical Center have been presented. Only 14.3% or 1 in 7, of these patients had carcinoma in situ. Advanced disease in young patients is discussed. Mass cytologic screening of women in the geographic areas involved, with suggestions for such a program is also discussed.

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Pertinent Paragraphs

A continuing education demonstration center for physicians and other personnel is the long range goal of a contract signed May 2, 1966, by the U. S. Public Health Service's Division of Community Health Services and the University of Illinois, College of Medicine. The center, to be developed and operated by the University of Illinois, will serve as a model for the ultimate establishment of similar centers in other institutions.

No one can deny that the provisions of the Federal Food, Drug and Cosmetic Act and its Amendments are in the public interest and promote drug safety to a degree not surpassed anywhere in the world. But it must be recognized—and this I cannot stress too strongly—that the provisions of these drastic and far reaching amendments should be administered in a scientific and flexible manner. An overly strict interpretation and application of the legal and regulatory language of the recent Amendments could stifle the development and production of new drugs. To regulate the production and use of drugs by responding to pressure groups and to the whim and fancy of biased and overly critical individuals whether lay or scientific, would be a disservice to the public. — Joseph F. Sadusk, Jr., M.D., to American College of Physicians, New York, April 19, 1966.

There is no simple answer to the question "How Safe are Drugs?" The effective drugs available today have varying degrees of potentiality for producing harmful effects. Can drugs be developed with such specificity of action that all effects but the one desired would be eliminated? This is something to hope for but the reactive mechanisms of the body may also have limits of specificity. If we have to live with new drugs which occasionally produce adverse effects, less trouble will occur if the physician uses them wisely. He can do this only by learning as much as possible about them before he prescribes them and then passing along any additional information gained from his own experience.—Ralph G. Smith, M.D., in *Journal of New Drugs*, (6:62-68), January-February, 1966.

The "animal protectionist" groups have mounted the greatest offensive against the effective use of animals in biological research and teaching that has ever been attempted in the United States. Today in Congress there are bills to which about 40 congressmen have attached their names, dealing with procurement, housing, care, and use of experimental animals. The present mood of Congress is to accede to the demands of the vocal animal protectionist minority and pass some sort of legislation. Every physician and biological scientist who has a sense of public responsibility should be informed of the issue and communicate his views to his congressman as to public harm that might be done by unwise legislation. — Maurice B. Visscher, Ph.D., M.D., in *Modern Medicine*, (34:87), March 14, 1966.

The new drug regulations were created because of certain problems which needed correcting. In an effort to be precise and encompassing, the wording was made all-inclusive. When interpretation and enforcement subsequently followed, it has been found now that not only was the total drug industry brought under complete government control, but also the whole of medicine. This means not only one phase of medicine, but the whole spirit of medicine has been made captive. — James H. Johnson, M.D., in *Annals of Allergy*, (24:88), February 1966.

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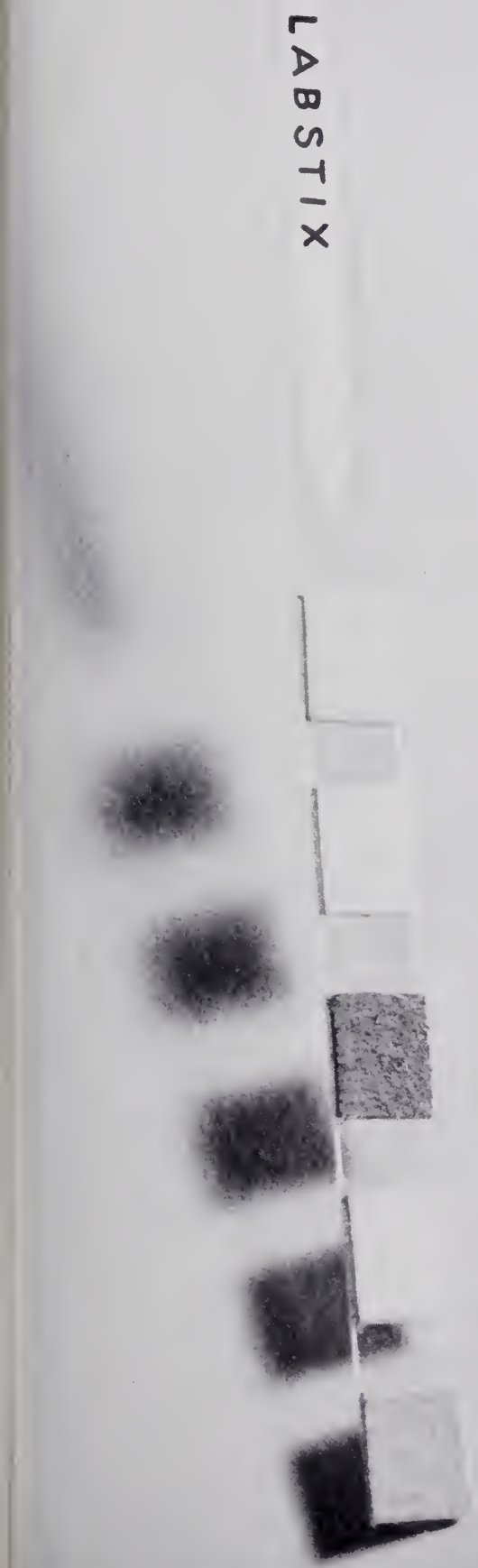
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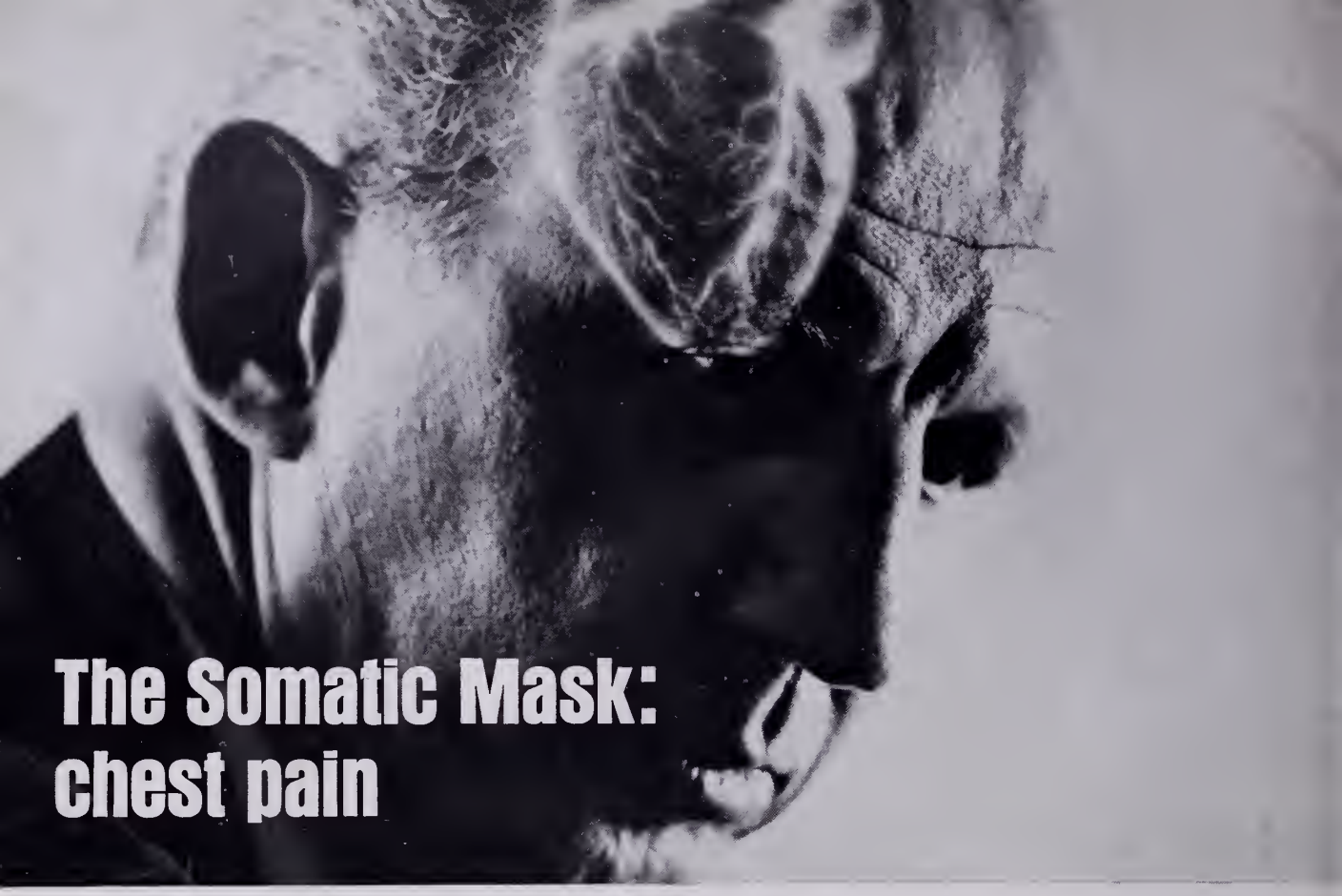
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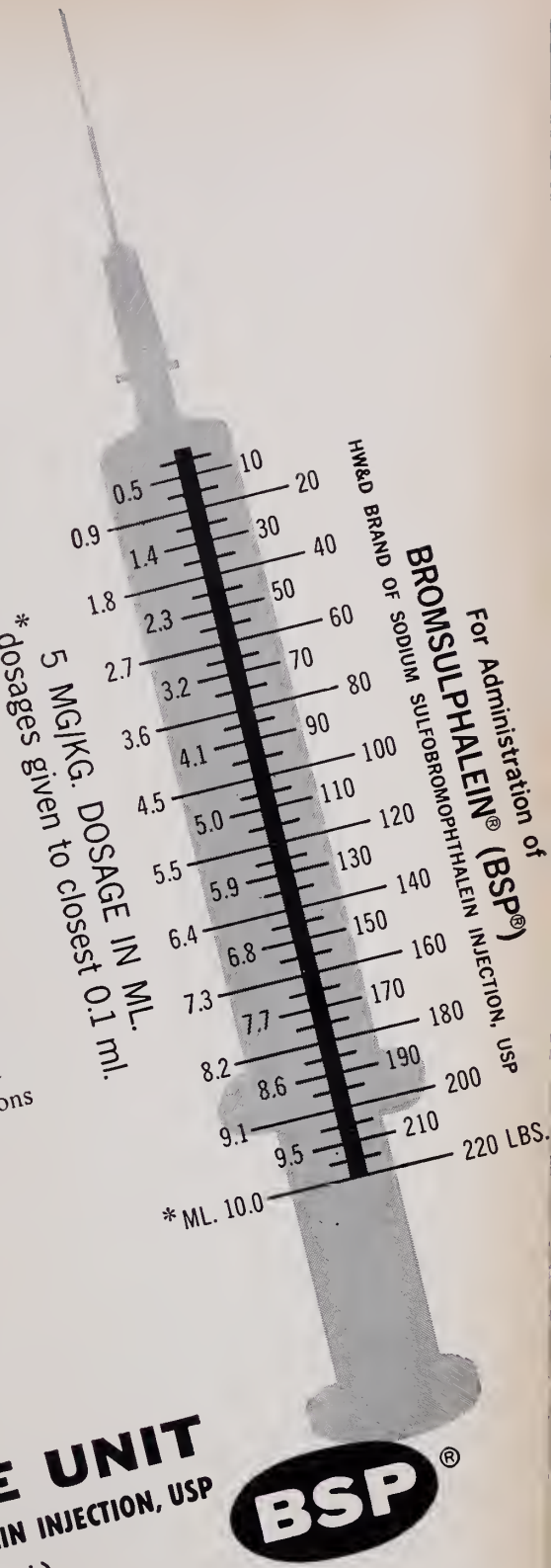
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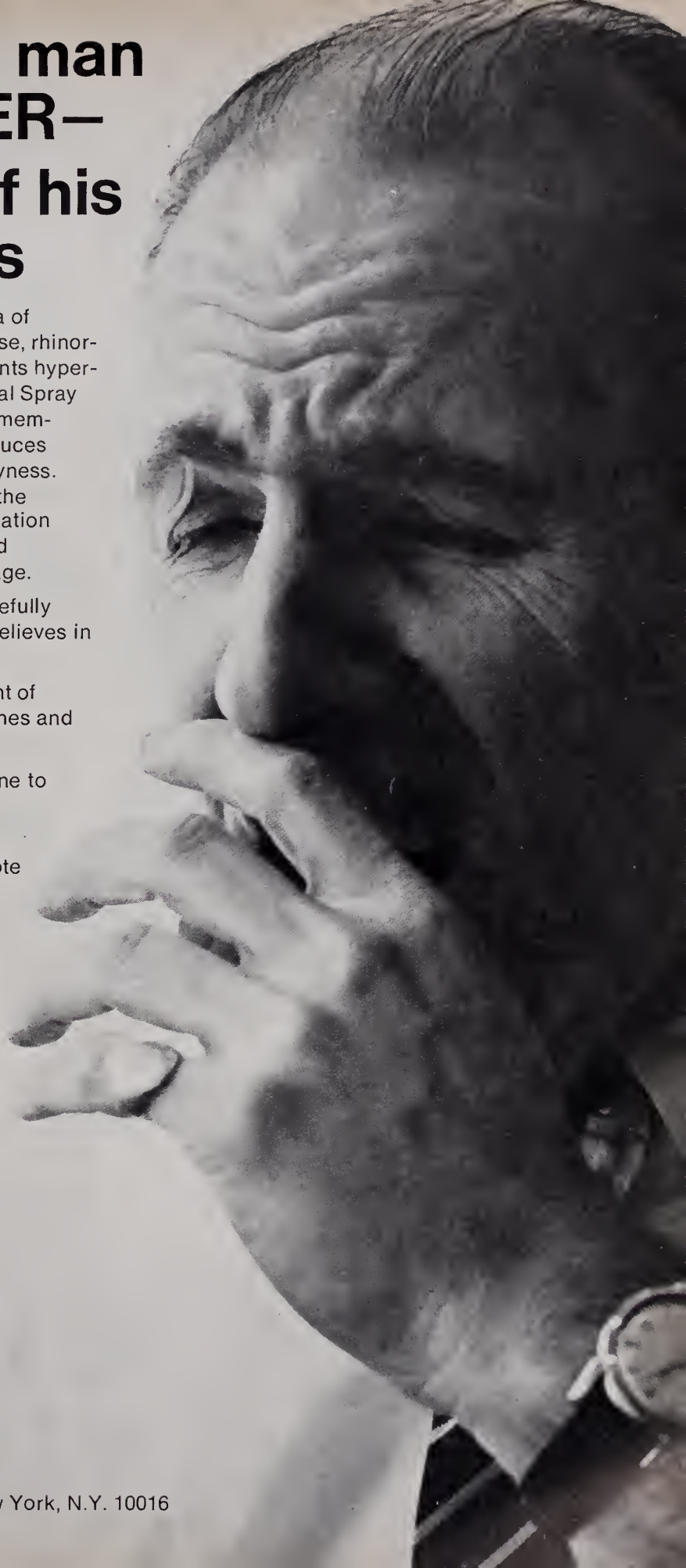
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REGULAR FEATURES

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Once merely a man with HAY FEVER— now a victim of his own antibodies



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MESSAGE FROM THE PRESIDENT



A Decision To Be Made

IT MAY BE SAID with considerable truth that many of us have not done our full share in preventing the onset of Medicare. Be that as it may, it is now with us, and that which we do henceforth must be within the framework of Medicare. With this in mind, let us not forget that the battle to prevent the socialization of medicine is not finished at this point, and our actions now and in the future will still be responsible for helping guide the course of American medicine.

At the present time, each of us as practicing physicians must decide how we will handle medical insurance benefits within the Medicare program. As you know, there are two choices, and the method to be used is a matter for agreement between the doctor and the patient. One method somewhat maintains the traditional patient-physician relationship, while the other involves the third party concept which is an anathema to most of us.

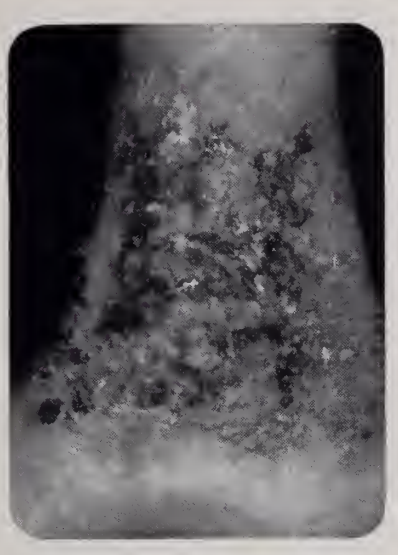
Although each physician must decide for himself how he is to practice medicine, it would appear, to this writer at least, that it would be more in keeping with the free practice of medicine to expect the patient to be responsible for his medical fee. To do otherwise would, in my opinion, be a mistake. There are too many people today who have no sense of responsibility and not only want but expect others to pay their bills. The principle of individual responsibility is basic to any free enterprise system.

Although this is a decision for the present, there will be others in the future just as important. Let us consider each on its own merit and try at all times to do that which will be in the best interest of American Medicine.

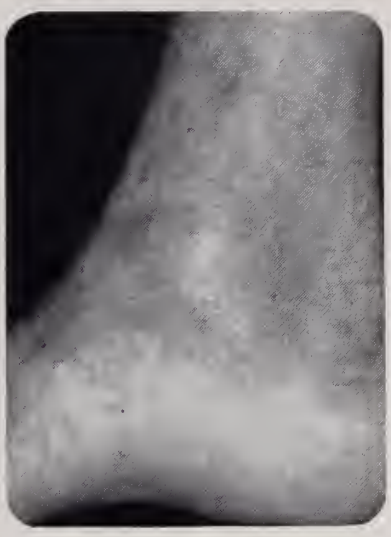
C. C. Lowry, M.D.
KMA Vice President (Western)

†*This is the fourth in a series of four guest articles written at the request of KMA president, Everett H. Baker, M.D., by the president of the Woman's Auxiliary and the three KMA vice-presidents.*

eczema: scourge of childhood



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JULY

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AUGUST

6-7 KAGP Elizabethtown Seminar, Holiday Inn, Elizabethtown

21 KAGP Bluegrass Seminar, Imperial House, Lexington

SEPTEMBER

20-22 KMA ANNUAL MEETING, Convention Center, Louisville

OCTOBER

6 KAGP Maysville Seminar, Health Department Office, Maysville

13-16 American College of Obstetricians and Gynecologists (ACOC) District V. Meeting for physicians and nurses, Stouffers Inn and Brown Hotel, Louisville

27 KAGP Symposium on Clinical Emergencies, Executive Inn, Louisville

31-Nov. 12 PG Course in Otolaryngology and Bronchoesophagology, University of Louisville Medical Center

IN SURROUNDING STATES

JULY

25-29 Interpretation and Therapy of Cardiac Arrhythmias, Symposium by Hahnemann Medical College and Hospital, at Marriot Motor Hotel, Philadelphia

AUGUST

12-13 AMA National Conference on Infant Mortality, Fairmont Hotel, San Francisco

25-27 West Virginia State Medical Association Annual Meeting, The Greenbrier, White Sulphur Springs

27-Sept. 2 American Congress of Physical Medicine and Rehabilitation and American academy of Physical Medicine and Rehabilitation, joint meeting, Sheraton Palace Hotel, San Francisco

29-Sept. 1 American Hospital Association, Palmer House, Chicago

SEPTEMBER

5-12 Third International Congress on Human Genetics, University of Chicago

8-10 American Association of Obstetricians and Gynecologists, Hot Springs, Va.

11-16 Flying Physicians' Association, The Dunes Hotel and Country Club, Las Vegas

20-28 Tenth Congress of the Pan-Pacific Surgical Association, Part I, Honolulu, Hawaii

25-30 Michigan State Medical Society Annual Meeting, Pantlind Hotel, Grand Rapids

26-27 Tennessee Valley Medical Assembly, Tivoli Theater, Chattanooga

OCTOBER

1-5 American Society of Anesthesiologists, Sheraton Hotel, Philadelphia

7-14 American Academy of General Practice, War Memorial, Boston

7-8 Congress on Medical Quackery, Pick-Congress Hotel, Chicago

10-14 Annual Clinical Congress, American College of Surgeons, San Francisco

10-12 Indiana State Medical Association Convention, Sheraton Hotel, French Lick, Ind.

11-14 Pennsylvania Medical Society Annual Meeting, Pennsylvania Sheraton Hotel, Pittsburgh

15-16 American Association of Ophthalmology, Palmer House, Chicago

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References: 1. Telfeyan, S. A.: Clin. Med. *70*:1668, 1963. 2. Shepard, H. L.: J. Am. Geriatrics Soc. *11*:363, 1963. 3. Cummings, D. E.; Goodman, R. M., and Steigmann, F.: J. Am. Geriatrics Soc. *12*:161, 1964. 4. Castleman, B., ed.: New England J. Med. *268*:1462, 1963.

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PUBLIC HEALTH PAGE

A Cervical Cytology Program for Kentucky †

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

EACH of us, at some scientific or professional meeting in the past few years, has heard a speaker deplore the "time lag" between the development of a medical technique or process and its application in general practice. Probably no more precise example of this lag can be cited than the continuing incidence of cervical cancer. Doctors Papanicolaou and Traut published their findings in the early 1940's. Ten years later a United States Public Health Service Project in Memphis and Shelby County, Tennessee, demonstrated the unquestionable value of the technique in the detection of unsuspected cervical cancer. Yet in 1960 only 60 per cent of the respondents in a national Gallup poll had heard of the Papanicolaou smear and only 30 per cent had had the test.

Current figures for Kentucky, if they were known, would most probably not exceed those for the nation six years ago. Only this Spring, two locally sponsored cervical cancer detection programs were conducted with intensive publicity and appeals to come in for the test at no charge. In one of the counties with approximately 1,600 women 20 years of age or older, only 157 women made appointments for the test and only 135 (86 per cent) kept the appointment. In a larger county where there are around 7,000 women in the same age group, only 544 came to three well-advertised evening clinics and many of them were women who attended a similar clinic two years ago.

Despite the pessimistic picture presented by the figures the future looks very encouraging. This optimism comes from the constantly increasing evidence that the medical profession is concerned about the deaths from cervical cancer in Kentucky (522 in the three-year period ending in December, 1965) and are giving wholehearted participation in planning and conducting detection programs.

On July 1, of this year the State Health Department will inaugurate a program designed to demonstrate (1) the value of the Papanicolaou test for individual health and prolonged life, (2) the simplicity of the test, (3) the obvious advantages of including it as a routine part of every complete examination of a female patient, (4) the need for careful and complete follow-up, and, of course, to discover unsuspected cancers and carcinomas in-situ. A major share of the credit for this program should go to the state's medical community for their support of the budget request which made it possible and their unselfish participation in its planning.

With this kind of cooperative effort, experiences such as the one described in the following letter should become a commonplace occurrence in Kentucky. The letter was written this Spring following one of the detection clinics mentioned above.

> "How does a person thank so many people for saving her life? I don't know, but this I would like to try and do. Four weeks ago I came to your cancer clinic and took a "Pap Smear" test. I really thought it probably wasn't necessary because I thought I was too young (32) to have this type cancer. But, I had never taken the test before so I would take it. The next Tuesday Doctor T_____ called me and said my test was abnormal and he wanted me to come to the hospital and have a specimen taken to be sure. All of it sure came as a shock to me. When this test came back it was positive. You can imagine how I felt. I felt as though my whole world had fallen from under me. Doctor T_____ said that it was in the first stages and I was extremely lucky to have found it now. I had my surgery two weeks ago today and am doing fine. I only had to have my uterus removed and there was no pre-invasion, was the report back. The doctor said my chances of not ever having cancer again are above 90 per cent. Had I waited even one year they would have dropped to 50 per cent. So I was truly lucky.
>
> May I say thanks to your department, all the ladies that helped, nurses, doctors, and everyone least involved in helping to save my life.
>
> God bless this good work you have started and may you be able to continue it so other women can be as lucky as I was."

† *This article was prepared by The Office of Chronic Disease, Division of Epidemiology, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky 40601*

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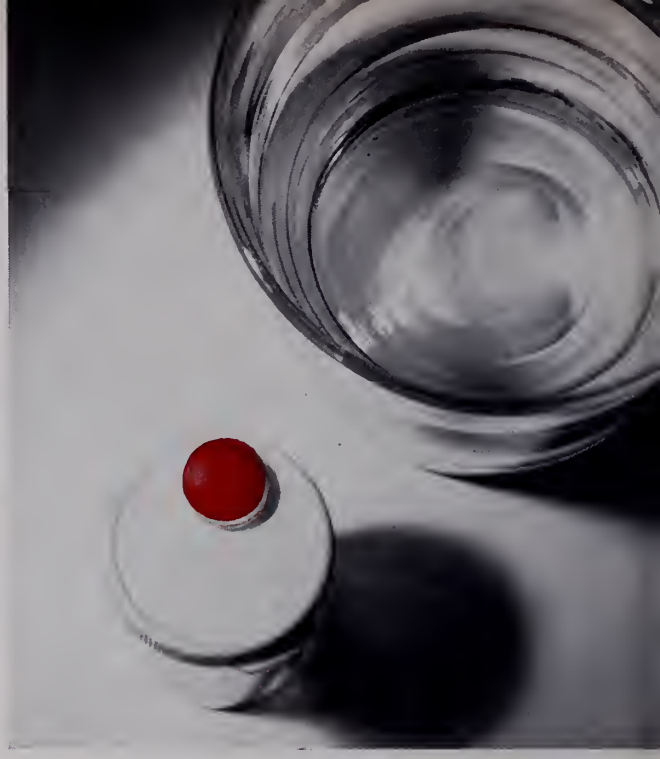
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Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

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HERITABLE DISORDERS OF CONNECTIVE TISSUE: by Victor A. McKusick, M.D.; Published by The C. V. Mosby Company, Saint Louis, 1966; Third Edition, 499 pages; Price, $18.50.

Books are living things. From the moment of conception to that joyous day of birth, they are nurtured, nourished, and cultivated by arduous labor. Some books quicken only to die. These seemingly have not been properly conceived. Others appear sound at birth but somehow never fullfill the high hopes envisioned by author or publisher. Still others mature and successfully reproduce themselves, with minor alterations, in edition after edition. McKusick's book belongs to the last category.

Since 1956, this work has undergone two revisions. The great eruption of scientific information has added much that is new. As a volume on heritable disorders of connective tissue, this work has fortunately been grafted on McKusick's superb background in bedside medicine.

The few color photographs are eye catching. Reading is easy as the prose flows smoothly and untroubled. The third edition maintains the high standards set by its predecessors.

No single volume written in the English tongue contains such a wealth of information. McKusick's book should be within easy reach of every physician who has a practice.

This volume succeeds where others have failed. Deftly it cuts across the multitude of medical disciplines spawned by the twentieth century. More cannot be asked of any medical work.

ABRAHAM M. GORDON, M.D.

FIFTH NATIONAL CANCER CONFERENCE PROCEEDINGS, 1964, coordinated by Roald N. Grant, M.D.; Published by J. B. Lippincott Company, Philadelphia and Montreal, 1965; 759 pages.

Since 1950, the American Cancer Society and the National Cancer Institute have jointly sponsored nation-wide cancer conferences every four years. These have generally been well attended, excellent programs of high quality, representing the best minds the nation brings to bear on the problem of cancer. The Fifth Cancer Conference held in September, 1964, in Philadelphia, in conjunction with the bicentennial observance of the University of Pennsylvania School of Medicine, was probably the best of this series of conferences.

This volume of the proceedings is nicely edited; it is divided into short sections, each giving a good clinical resumé of up-to-date management practices and end results in various regional cancers. Authors contributing new information on a particular kind of cancer have often been chosen for the presentations, so that one cannot use the volume as a conventional textbook. The most valuable portion of the volume is the first section on the epidemiology and biology of cancer. It concerns recent basic science contributions to our understanding of cancer. This material has not had time to reach textbooks, but constitutes much of the fundamental knowledge of neoplasia. All doctors caring for cancer patients should read the various presentations in this section; the easy-to-read papers will not necessarily change anyone's ideas about treatment and management overnight, but they reduce our confused thinking about the behavior of cancer in the human body. There are few places where one can read simply stated reviews of this material.

The sections on cancer of the breast, leukemia, tumors of bone, systemic effects of cancer, and preoperative radiation are outstanding. In short, this is as good a reference book for the clinician on certain regional cancers as is available especially for the coverage of recent developments and recent problems.

CONDICT MOORE, M.D.

SURGERY IN AMERICA: FROM THE COLONIAL TWENTIETH CENTURY, Selected Writings; edited by A. Scott Earle, M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1965; 280 Pages; Price, $8.50

The editor of this well produced little book is a practicing surgeon in Sun Valley, Idaho, who is in the process of writing a history of American surgery. The present book is a collection of the writings of surgeons who have contributed to the growth and development of surgical science in America.

It is apparent from the selections the editor has chosen that he has a thorough knowledge of the surgical literature. Some of the selections are reprinted complete in their original form, others have been carefully abstracted. The abstracts have been skillfully done and add to rather than detract from the overall interest of the volume.

Doctor Earle has written a succinct introduction, including a very brief biographical sketch, to each of the reprinted papers which "sets the stage" for the reader who may not be familiar with the author or the subject matter he presents. Individuals, obsolete terms, and older drugs that appear in the reprinted text are identified in footnotes. Very kindly the publisher has placed the footnotes where they are most useful — at the "foot" of the page. Occasionally

important correlative information is also supplied in a footnote.

The papers are presented chronologically from the first published accounts (in newspapers!) of surgical operations in the Colonies performed by Zabdiel Boylston (1679-1766) up to William Steward Halsted's (1852-1922) commentaries on "The Training of the Surgeon." There are 24 carefully selected papers on surgical subjects including those of John Collins Warren (1778-1856) and Henry Jacob Bigelow (1818-1890) on the introduction of ether anesthesia. All of these papers appear in other publications, many however, would be virtually unobtainable without considerable time and effort. Doctor Earle and the publisher, W. B. Saunders Company, are to be commended for presenting physicians with a fine selection of surgical milestones, ably introduced and identified. There is a selected bibliography and an excellent index which even includes persons and subjects referred to in the footnotes.

This book should be read by all who perform surgical operations and could provide several evenings enjoyment for those physicians interested in medical history.

EUGENE H. CONNER, M.D.

CURRENT PEDIATRIC THERAPY 1966-1967.: Sydney S. Gellis, M.D.; and Benjamin M. Kagan, M.D.; W. B. Saunders Company, Philadelphia and London, 1966; 956 Pages; Price $17.50.

This volume consists of nine hundred and fifty-six pages and is divided into twenty-five sections written by two hundred and eighty-six outstanding contributors who are well known for their clinical experience with the disease entities for which they were selected by the editors to write. It is well indexed and the reading material is concise and simple. It will serve as a quick reference for the physician faced with the therapeutic management of an illness which he may encounter only casually. The physician may proceed with his therapeutic management with full knowledge that the effectiveness and safety of new antimicrobial agents, new vaccines, and new drugs are based on the experience of clinical investigations and are recommended by two hundred and eighty-six leading contributors who have been selected to write sub-sections of the text.

WALTER M. EDWARDS, M.D.

"Ill-advised statements and actions since the thalidomide phenomenon aided by the unbalanced perspective given these statements in the lay press, have contributed to the public's apprehension — approaching hysteria — concerning the side effects of drugs. To the extent that this concern admonishes greater caution and alertness in the use of drugs, some good may be salvaged from the thalidomide tragedy. But to the extent that it deprives patients of useful new drugs or frightens a physician into withholding needed therapy from his patients, it is regrettable. We must not forget that there is no progress without risk, whether it be in the field of electricity, the motor car, the airplane, atomic energy, space exploration, or drugs. Even a bathtub can be perilous, as astronaut John Glenn discovered. Theodore G. Klumpp, M.D., in *Massachusetts Physician,* (28:207-208), June-July 1965.

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Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
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Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

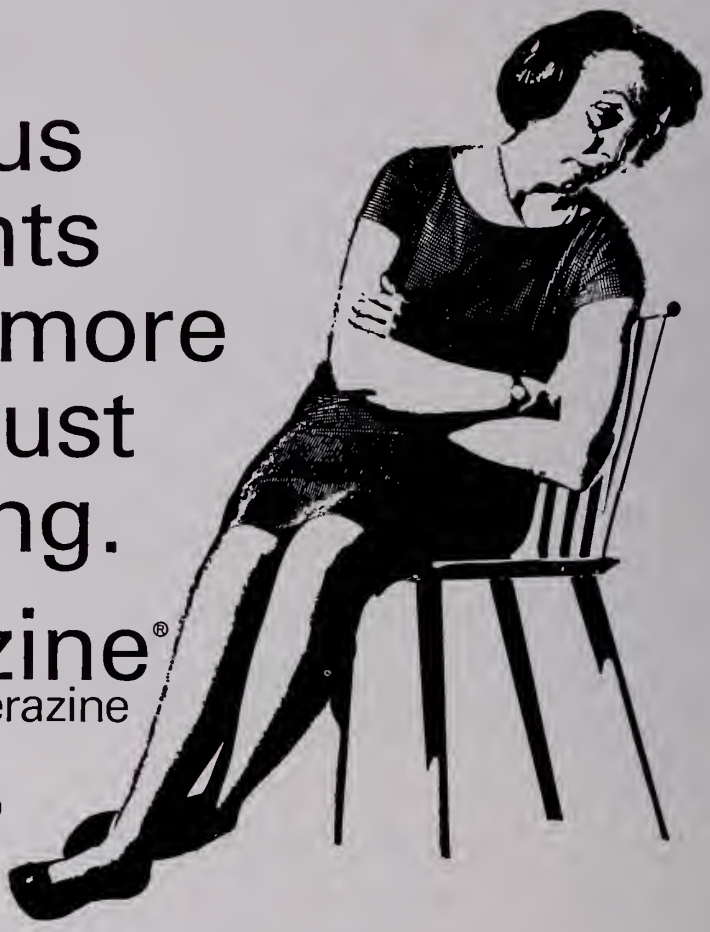
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The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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THE INSURANCE PAGE



Blue Shield: Annual Report

IN ITS recent annual meeting in Chicago, officers of the National Blue Shield Association evaluated past performances of their plans and discussed prospects for the future.

Blue Shield's growth in both membership and benefit payments reached record highs during 1965, while operating expenses, a gauge of efficiency, fell to an all time low. Enrollment increases during the year brought Blue Shield coverage to 27.3% of the population. Benefits paid out during the year amounted to over 90% of subscription income.

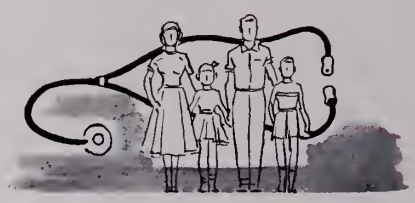
The extent and quality of Blue Shield coverage continued to increase during 1965. Studies and experimentation are being carried out on new types of programs, such as dental coverage, increased psychiatric coverage, and other. Activities to minimize program abuse and promote effective use of health services are continuing. Utilization review activities, Blue Shield informational services, and public relations programs have increased.

Co-ordination of benefits, another program designed to prevent over-utilization of the health care dollar, received increasing attention from Blue Shield plans during the past year. Co-ordination of benefits recognized the fact that when both a husband and wife work, they are quite often covered by family contracts on two different health care programs. If either the husband or wife becomes ill, it is possible for both of them to collect against their health care program. With co-ordinated benefits, a "primary carrier" is designated in advance, and the other carrier covers only the unpaid balance, thus eliminating wasteful excess payments.

Data processing equipment has been adapted to fit the claims handling needs of plans throughout the country, and is being used extensively. New methods of utilizing data processing equipment in the plan's operations are being studies and implemented every day.

1965-66 has been a significant and critical year for Blue Shield and for the medical profession. With passage of the Medicare Law, health care in this country has embarked on a radical new course. The future of medicine's control of its own environment depends to a great extent, on improvement and expansion of existing voluntary programs, and creation of new ones as the needs become apparent. A united and strong medical profession, working with its fiscal right arm, Blue Shield, will be an effective deterrent to total state medicine.

WILLIAM W. HALL, M.D.





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Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

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The JOURNAL of the
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VOLUME 64 July 1966 No. 7

Teaching Community Medicine in the 'Hospital Without Walls'†*

JESSE W. TAPP, M.D.** AND KURT W. DEUSCHLE, M.D.***

Lexington, Ky.

The background, development, aims and methods of a unique new teaching program in Community Medicine at the University of Kentucky College of Medicine are outlined.

THERE ARE TWO parallel but unequal forces in medical education today. One is pressing the student of medicine further and further toward the solving of disease problems on the molecular level. The other force is the enormous challenge of overcoming the many health problems among the people in our community, nation, and world. The challenge of laboratory problems is communicated much more effectively in the medical schools than is the challenge of the social medical problems of the community; moreover many medical schools do not have the teaching resources that would enable them to involve their students in health problems of our society in an equally challenging, stimulating and attractive way. Yet it is only when the health problems of our society can be presented on a comparable basis to the problems considered in the clinical ward and research laboratory that students will be attracted to career opportunities in public health and community medicine.

An unfortunate dichotomy exists for many students and physicians between clinical medicine and public health. As the prevalence of infectious diseases has declined, there has been a decreasing interest in public health on the local level on the part of the physician in private practice. Many local health departments have become no more than caretaker units for vital statistics and immunization programs. At the same time, public health at the national level is becoming much more complex with new legislative programs concerned with medical care services throughout the country.

This, then, is a propitious time for the development of a department in a medical school which would have as its major purpose teaching and research regarding the identification and solution of community health problems. Such a department could amalgamate the interests and forces of various specialty medical disciplines within the school and relate them to problems seen in the community. In addition, such a department would be able to work with the private physician and with

†*Presented before the joint meeting of the sections on General Practice and Preventive Medicine, at the AMA Annual Convention in New York City, June 23, 1965.*

**The extramural teaching program described is supported through a grant from the Commonwealth Fund of New York.*

***Associate professor of community medicine at the University of Kentucky Medical Center, Lexington, Ky.*

****Professor and chairman of the department of community medicine at the University of Kentucky Medical Center.*

Reprint requests to Department of Community Medicine, University of Kentucky Medical Center, Lexington, Ky. (Dr. Tapp).

the public health department and other voluntary and official health agencies, serving as a bridge between the academic world on the one hand and the practice of medicine and public health on the other.

The prospect of teaching medical students away from the University Hospital was first clearly demonstrated to the author (KWD) in the Navajo Many Farms Cornell Project in Arizona. Students from Cornell were taught on an elective six week clerkship in principles of epidemiology and public health. A live community was the subject, and the field faculty were the tutors for the student. In this setting students would often remark "if this is public health, I like it".

An opportunity came in 1960, with the opening of a new medical school at the University of Kentucky, to undertake the establishment of an entirely new department[1] of preventive medicine and public health. The "name" was left to the discretion of the new chairman. This departmental program was to permeate the entire curriculum and compete for the students' interest and respect with the traditional disciplines of medicine, pediatrics and surgery. The dean of this medical school, Doctor William R. Willard, not only condoned but encouraged progressive development of a new department which would relate hospital medicine to the community at large. One of the major objectives of the medical school was to graduate physicians who would eventually be able to take on the first line responsibilities of family practice and concern themselves with the problems of health in the entire community.

The Teaching Method

What type of new educational program could provide the academic experiences necessary for the student to become sensitive to community health problems? Several reports in the literature detail the teaching program which has evolved in Kentucky.[1,2,3,4,5] Following a classroom course in epidemiology in the second year, each student is assigned to study a real community somewhere in the state during a required six week clerkship in his senior year (Figure 1.). It is in the community situation that the student sees family practice and public health first hand. He has access to or may be primarily located in a family doctor's office where he observes the pattern of patient problems which the usual physician must treat in a community. He has access to the doctor's clinical records and can see whether they are adequate for epidemiologic study of on-going medical practice. Where possible, then, such studies have been carried out. The student learns how a physician relates to the total community, how he works with his colleagues, both general practitioners and specialists, how he operates in

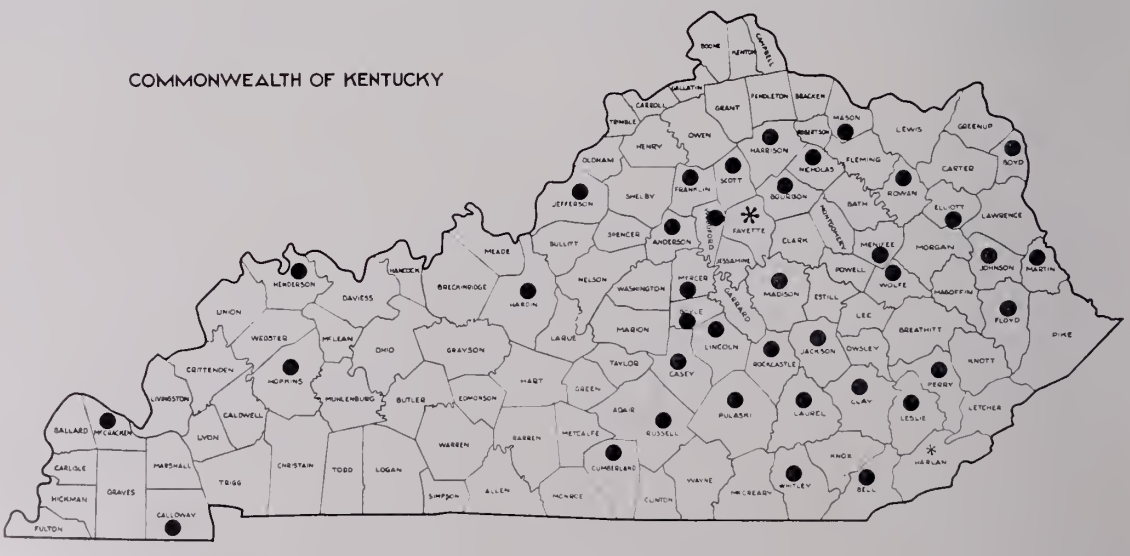


FIGURE 1. Map of Kentucky showing the distribution of Community Medicine Clerkships throughout the state in the academic year 1964-65.

the community hospital setting, and how he keeps up with his continuing education.

The student has a chance to study family practice as potentially a true specialty, wherein the natural history of disease as it occurs in a population group can be seen. This opportunity is critically important because, out of 1000 people who may be ill in a community, only one may be referred eventually to a University hospital.[6] A very biased view of medicine results when the student has the opportunity to see patients only in the setting of a hospital ward of a medical center. Furthermore, in the context of family practice, the student has the opportunity to study in depth more of the major social problems wrought by such long term illnesses as stroke, diabetes, cancer, or tuberculosis.

However, instead of having the virtually unlimited resources of the University Hospital, the student must face these major health problems in the actual community, which has limited resources. In some instances students are confronted with rural areas where there is nothing beyond the services of the local physician or drug stores; other students in urban areas have a wide variety of resources from which they must select the most appropriate for particular needs.

In the same community assignments the students work with local health officers, sanitarians, health educators, public health nurses, and social workers in the context of solving problems and participating with a team on daily assignments. This is a far cry from the afternoon field trip experience where students are taken to see a sausage plant or a garbage dump. The bulk of the students' time is spent in studying the total community, usually an entire county. The students must know the details of the whole population, historical background, occupation, education, age, race, and sex compositions, etc., because these people are the hosts of the diseases seen so episodically in the intra mural hospital ward.

Epidemiologic project possibilities are very diverse for defining the extent of major disease problems, exploring possible causal associations, and indicating appropriate preventive or curative measures. Figure 2 shows some locations where students have become intimately involved in designing and carrying out typical projects: glaucoma screening in homes for the elderly; tetracyline staining of the teeth in children; endemic goitre studies; associations between chronic respiratory disease and smoking and air pollution; tuberculosis case finding and mass treatment; emotional illness surveys and cervical cytology screening of women industrial employees; and examinations of school children for nutritional status, etc.

The mainstay and focal point of the community medicine teaching centers around the medical students living in the communities, working with the medical leadership and local citizenry. They are supervised closely through

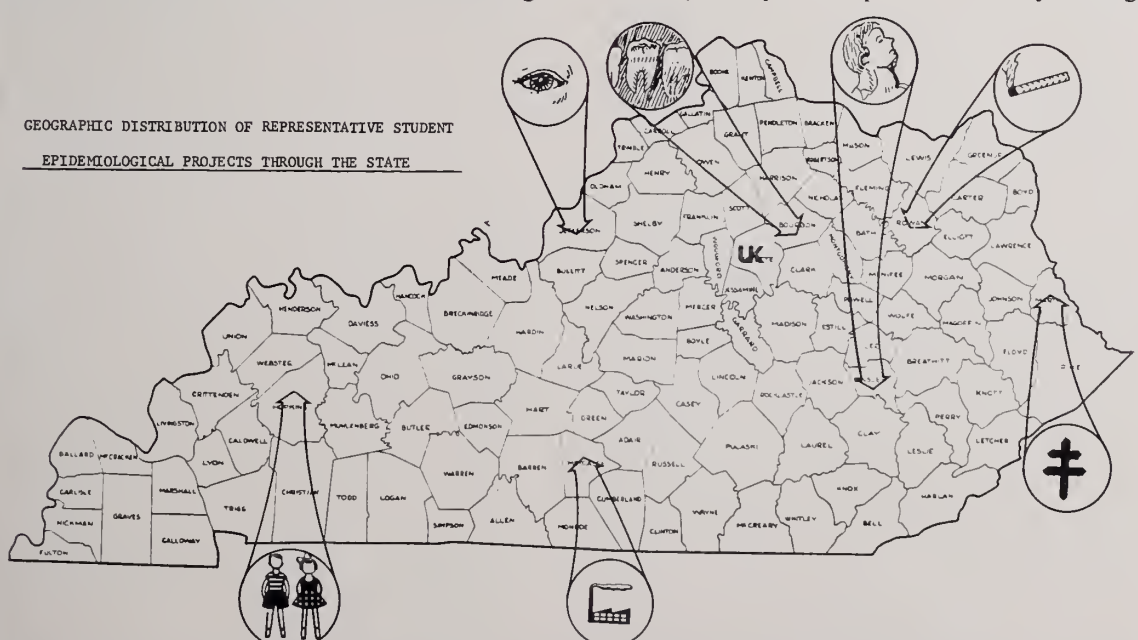


FIGURE 2. Map of Kentucky showing the counties where representative epidemiologic projects have been undertaken by students throughout the state, as described in text.

weekly teaching visits by a full time physician faculty member. Further help is provided by the anthropologist, public health social worker, and others of the medical center staff. Such intimate supervision and one-to-one faculty contact provide the students with the stimulus and encouragement to undertake the identification and solution of health problems not always immediately obvious in the communities. Occasionally the results of these community studies are reported in the medical literature.[7]

Often students have shown special interest in problems of the community such as genetic or familial abnormalities, family planning, evaluation of medical care, etc. Some of these students have elected to take a three-month program in their senior year to advance their knowledge and skill in epidemiology and public health. In addition, ten to twenty percent of the classes have been sent overseas to undertake epidemiologic and community health studies in such foreign settings as Iran, Colombia, Uganda, Bolivia, Turkey, Chile, etc.[8,9] It is hoped to continue these international assignments because the students are favorably influenced to appreciate the principles and concepts of public health. The health needs of the world, particularly the relationship between poverty and disease, are dramatized, but even more, these students gain a new perspective on the health problems seen at home.

The overall objective of the teaching approaches described above is to enable the student to establish sound priorities of need for his own medical career and for the society in which he will live and practice his profession. The physician of tomorrow must be prepared to evaluate the changing needs of his community and update his own abilities and attitudes accordingly. With our rapidly expanding body of medical knowledge and population size, the physician must become as adept at dealing with groups of people, families, schools, industrial workers, etc., efficiently and effectively as he does with his individual private patient. Experience in the hospital without walls is a promising means to achieve this goal.

Discussion

Public health education for medical students must move toward union with family practice education. Just as Flexner's report in 1910 showed the need for improved academic status of all medical education and for patient centered clinical experience, so today the current needs of public health and clinical medicine must be seen. The physician needs to be trained to function as a leading member of the community health team. However, this educational approach must be consistent and continuous with the now traditional patient-centered training. This can and will be done if the *concrete* hospital walls cease to be the boundaries of our classrooms, as suggested by Rene Dubos.[10] The concept of quality hospital ward teaching can be extended to communities wherever they exist!

The fact that good medical education is very expensive is widely recognized and accepted.[11] This is due largely to the necessity of providing facilities and care for the sick at increasingly high cost. Although transportation, faculty time, and project expenditures for required community clerkships are costly in themselves, the current annual expenditure for these at the University of Kentucky is less than the annual cost of maintaining four university hospital beds. Students are enthusiastic in their endorsement of the unique contribution made to their education by these extra-mural experiences. Participating physicians are quick to acknowledge that they would have avoided costly mistakes in their own careers had they had a similar orientation in their professional training.

The ways in which health services are provided and utilized require study in order to improve effectiveness in meeting our increasingly complex needs. These studies are exciting and appealing to students and physicians alike when seen in the context of a typical community with all its economic, political, and social facets. Research in this realm will have to become as ubiquitous as laboratory research is today at the molecular level if our society is to resolve its problems in the quality and distribution of health services. A generation of physicians trained in the community to carry out such research and to design their medical practices accordingly will be better equipped to serve society.

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Tetanus Neonatorum

WALTON M. EDWARDS, M.D.*

Louisville, Ky.

Neonatal tetanus is now so rare that when it occurs in an infant delivered in a community hospital where aseptic obstetrics is practiced, the occurrence warrants a report.

THE incidence of tetanus has steadily declined in the United States, as has the mortality. The mortality from neonatal tetanus, however, continues elevated, ranging from 70 to 90% [1,2]. Tetanus is rare in the immunized person,[3] and when a septic obstetrics is practiced, the occurrence of neonatal tetanus warrants a case report.

Case Report

This infant was born in a community hospital of an uncomplicated delivery. At birth a plastic clip was applied to the umbilical cord. The mother and baby left the hospital on the third day. On the seventh neonatal day the infant was taken to a physician for a routine neonatal evaluation. The umbilical cord stump was necrotic and was removed. No local antibacterial agent was applied. There was oozing of serous material at the stump and during the following day the baby became irritable and restless. On the ninth neonatal day the mother called the County Health Department and was instructed to wash the umbilical area with soap and water and follow with the application of alcohol and a dressing. These instructions were followed, but the area began to drain seropurulent material. On the 11th neonatal day the baby became dyspneic, cyanotic and dysphagic. She was taken to a physician who administered penicillin, but the difficulty in swallowing progressed and she began to choke on her feedings, thus necessitating hospitalization. A nasogastric tube was inserted for feeding and on the 13th neonatal day she was transferred to Children's Hospital of Louisville with a presumptive diagnosis of tracheo-esophageal fistula.

Physical Examination: The patient's weight was 7 lbs. 8 oz. Her temperature was 99.8°, respirations 72 and pulse 180. She was in respiratory distress. Her mouth could not be opened forcibly. There was generalized muscular rigidity with labored respiration and suprasternal and subcostal retractions. Her abdomen was board-like in rigidity and her extremities were stiff, flexion and extension being impossible. The base of the umbilical stump contained granulation tissue and the edges of the adjacent skin were inflamed but there was no bleeding or seropurulent discharge. The neurological findings were exaggeration of the deep tendon reflexes and tetanic-like movements on painful stimulation of the extremities.

A spinal puncture attempt was unsuccessful because of the marked rigidity of the back muscles. Anaerobic and aerobic cultures from the umbilical cord were negative for pathogens. Blood chemistries revealed normal values for sugar, potassium, sodium, and calcium.

A diagnosis of neonatal tetanus was postulated on the basis of spasticity and stiffness of the extremities, tetanic spasms, rigidity of the muscles of the back and abdomen and inability to force open the mouth. The history of an oozing cord stump provided additional evidence in favor of tetanus, however, cultures for C. tetani had not been obtained initially and subsequent ones were negative.

The infant was kept in an Isolette and moved to a quiet room. Her temperature was never elevated. She immediately received 1,000 units of human hyperimmune antitetanus globulin intramuscularly. Pencillin and streptomycin were given for seven days and chlorpro-

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**Thorazine® (Smith Kline and French Laboratories)

***Amytal® (Eli Lilly Company)

mazine**, amobarbital*** and chloral hydrate were administered for sedation. Because of the possibility of aspiration, fluids and medications were administered parenterally and rectally.

There was steady improvement with a diminution in the degree of all muscle spasm. Oral feedings were commenced on the 30th day. All medications were gradually discontinued and she was discharged as recovered completely on the 36th hospital day, weighing 7 lbs. 4 oz.

Discussion

The failure to culture C. tetani from the umbilical stump is not unusual and does not rule out tetanus. Spivey *et al.*[3] found only three positive cultures for C. tetani among twenty-six infants with neonatal tetanus. Neonatal tetanus has been treated by various methods. Wilkinson[4] managed a group of African infants by using chloropromazine and mephenesin in addition to penicillin and antitoxin and reported a mortality of 48.6%. A plan of management of tetanus suggested by Hewett *et al.*[1] consists of the following:

1. Maintenance of an adequate airway.
2. Debridement of wound to remove source of toxin.
3. Neutralization of the toxin.
4. Control of muscle spasms.
5. Maintenance of nutrition.
6. Antibiotics which exert a bacteriostatic effect on C. tetani.
7. Maintenance of respiration.

In the patient herein reported, the above plan was followed. A tracheostomy was not required as the airway was adequate. The umbilical area appeared normal and no debridement was necessary. An adequate dose of antitoxin (human hyperimmune globulin)[5] was administered. Muscle spasm was controlled with chlorpromazine and sedation was maintained with chloral hydrate, phenobarbital, and sodium amobarbital. Feedings and antibiotics, which had been initially started by naso-gastric tube, were immediately discontinued because of the accompanying risk of aspiration and all fluids and medications were administered parenterally. Penicillin and streptomycin were the antibiotics of choice.[6] The recovery of this infant is believed to be due to the availability of a quiet room with constant nursing care and intense medical supervision administered by one physician with adequate consultations rather than a group, thus disturbing the patient as little as possible.

The prognosis of neonatal tetanus has been correlated with the incubation period[1], which has been reported as favorable if symptoms appear after the seventh neonatal day, but unfavorable if symptoms appear earlier. This patient had the onset of symptoms of tetanus on the 11th neonatal day which may have contributed to her recovery.

Summary

A 13-day-old infant was hospitalized with a diagnosis of neonatal tetanus, the onset of

(Continued on Page 596)

COMPOSITE OF MEDICATIONS:

Nothing by Mouth from 7 Aug. to 23 Aug.

Medication	Dose	Duration of Administration	Route
Human Hyperimmune *Antitetanus Globulin	1000 units	Immediately on admission	Intramuscularly
Penicillin	150,000 U. B.I.D.	12 Aug. to 19 Aug.	Intravenous
Streptomycin	50 mg q12 hr	12 Aug. to 19 Aug.	Intravenous
Phenobarbital	.015 gm. q12 hr	8 Aug. to 17 Aug.	Rectal Suppositor
Chloral Hydrate	100 mg. q6 hr	10 Aug. to 13 Aug.	Rectal Suppositor
Amytal	5 mg. q6 hr	8 Aug. to 13 Aug.	Intravenous
Thorazine	1.5 mg. q3 hr	8 Aug. to 22 Aug.	Intravenous

*Cutter Laboratories, Berkeley, California

Electrolyte Solution #48—500 cc. daily with added 25 cc. of 50% glucose 1000 cc. contains:

Dextrose 50 gm.	Lactate 23 mEq.
Potassium 20 mEq.	Sodium 25 mEq.
Chlorides 22 mEq.	Magnesium 3 mEq
Phosphate 3 mEq.	

Practical Tuberculosis Control for the Private Physician

Michael L. Furcolow, M.D.,* and Kurt W. Deuschle, M.D.**
Lexington, Ky.

With easier testing tools, lowered prevalence of infection and effective prophylactic medication, the private physician has available the necessary equipment for simple and practical control of tuberculosis in his practice.

FOR MANY years the private physician has been content to allow much of the treatment, diagnosis and finding of cases of tuberculosis to be done by the official agencies. This has come about largely because the X-ray was considered to be the best tool in the diagnosis of tuberculosis, and since mass X-ray was expensive and time consuming it soon fell to the province of the official health agencies. The most easily used diagnostic tool which the physician had was the tuberculin test which separated infected from non-infected. But since the average physician was of the opinion that most persons were tuberculin positive the test appeared to have limited usefulness to him. In addition, the instability of tuberculin solution tended to discourage the use of the test.

All of this has now changed. It is not only desirable but necessary that the physician undertake certain simple diagnostic procedures, thus doing not only his own case finding but securing knowledge upon which to base his decisions regarding prophylaxis. If tuberculosis eradication is ever to be accomplished, it has to be accomplished by the widespread use of the tuberculin test and the understanding of the principles of prophylaxis by the private physician. The findings being reported from many parts of the country indicate that the rates of tuberculin positive reactions do not exceed one to two per cent in children and 20 to 30 per cent in adults. It is quite clear, therefore, that all persons are not by any means positive to the tuberculin test.

The second practical advance has been to simplify the tuberculin test so it can be easily applied in the physician's office. This can be done by the use of the Tine test which consists of tuberculin dried on small prongs or by the use of a multiple puncture test employing liquid tuberculin. Either of these procedures is simple and relatively easy to apply by the physician or his nurse.

The third advance has been the development and application of isoniazid prophylaxis. It has been shown by the Public Health Service and other groups that prophylatic use of INH is both practical and inexpensive. Indeed, it costs but ½¢ a day to administer 300 mg of INH to a patient.

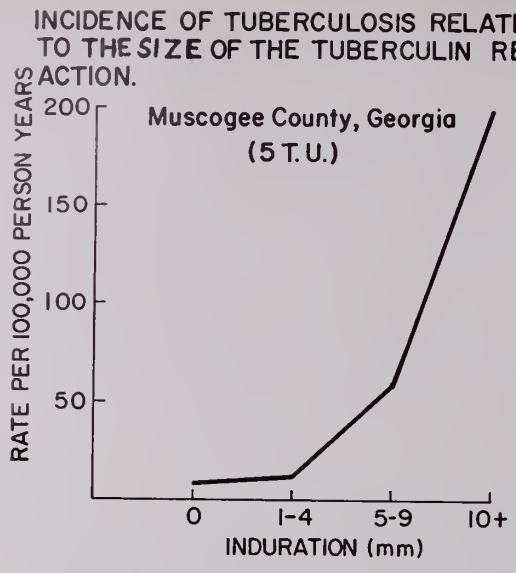
The physician, therefore, has in his hands a simple test with relatively low prevalence of positive reactors and simple rules for setting up high risk groups and a simple drug to use for prophylaxis in these high risk groups.

Risk Factors

It has been shown in numerous studies throughout the world that the risk of developing tuberculosis among infected (tuberculin positive) individuals is related to three primary factors, the size of the tuberculin reaction, the age of the individual and the sex of the individual.

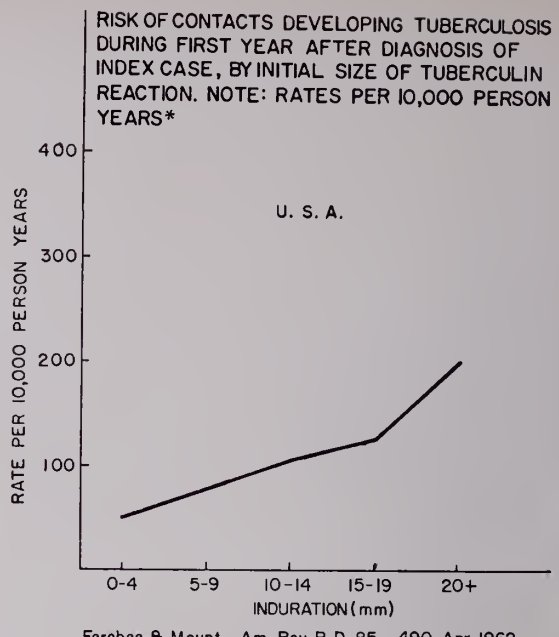
The size of the tuberculin reaction has been related to the development of active tuberculosis in many studies throughout the world.[1,2] Two from the United States, one from France and one from India will be used as illustrations. From Figures 1-4 it is easily seen that the larger the tuberculin reaction the greater the risk of developing tuberculosis. The second and third factors relating to the breakdown of tuberculosis are the age and sex of the in-

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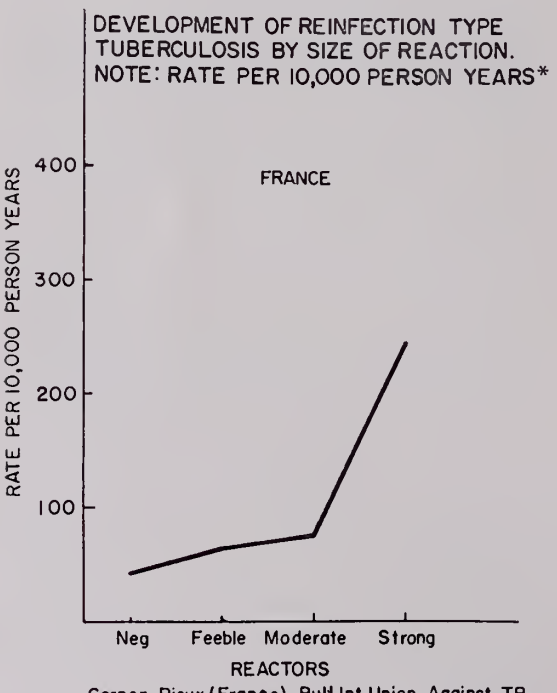
Comstock, George W., et. al. Public Health Reports 75, #583, 1960

FIGURE 1



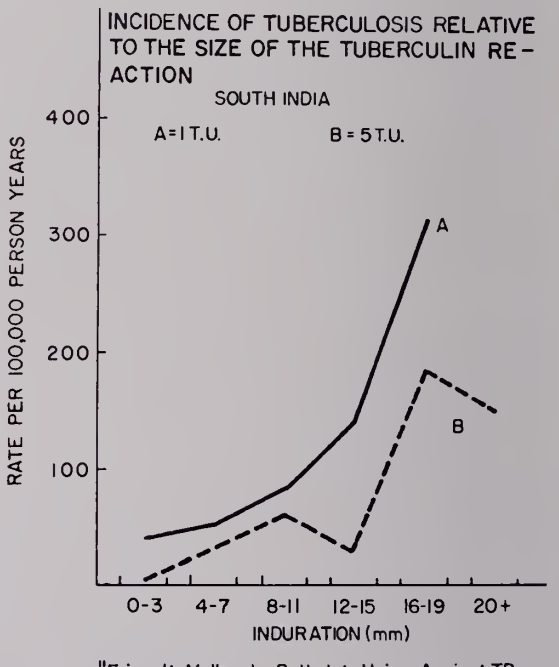
Ferebee & Mount, Am. Rev. R.D. 85, 490 Apr. 1962

FIGURE 2



Gernez-Rieux (France) Bull Int Union Against TB, 27 142, 1957

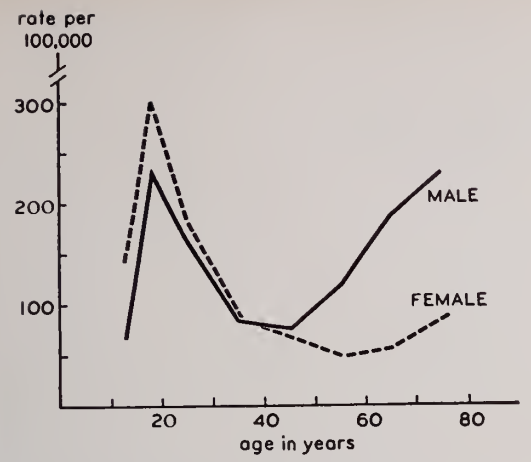
FIGURE 3



"Frimodt-Moller J., Bull. Int. Union Against TB. 27. 113, Jon. 1957"

FIGURE 4

dividual. These are illustrated in Figure 5 which shows that there is a marked difference in age and sex in the breakdown rate to tuberculosis. Not shown in the figure is the high rate of breakdown among infants and young children infected with tuberculosis, and indeed it is common practice for pediatricians to treat children under the age of 5 years who have a positive tuberculin. The period between the age of 5 and 15 appears to be a period with a low breakdown rate to tuberculosis. Beginning about the age of 12 in females and 15 in males, however, there is a sharp rise which continues until about the age of 35 years. During this sharp rise, the females exceed the males and may reach a rate of 300 per 100,-



Risk of pulmonary tuberculosis in tuberculin-positive persons, Ontario, 1960. From S. Grzybowski and E. A. Allen, The American Review of Respiratory Diseases, November 1964.

FIGURE 5

000 (3 per 1,000) person years. Following the age of 35 years the females remain consistently at a low level; whereas, the males, especially after the age of 45, show a steady, increasing rise with increasing age. It is quite clear, therefore, that sex and age do play an important part in the breakdown rate to tuberculosis.

By combining these three factors of size of tuberculin reaction and age and sex of the individual, a physician can relatively easily determine risks of development of disease among his patients. However, an even simpler method would be to consider the high risk group to consist of all persons with tuberculin reactions of 15 mm or greater induration on the intradermal test or 5 mm or greater induration on the Tine or other multiple-puncture tests. This high risk group would be put on prophylactic therapy for one year, consisting of 300 mg. of INH daily for an adult and proportionally lower doses (20 mg. per kilo) for children. This drug is easily taken, very acccptable to the patients and indeed creates a feeling of well-being.

In summary, a clear tuberculosis program can now be laid out for the physician in his private practice. 1) He should tuberculin test all of his patients, employing the most convenient method. 2) Among those who are tuberculin negative, re-tests might be performed but not more frequently than at two-year intervals unless the physician is practicing in an area where the rate of tuberculin positivity among his patients exceeds 50 per cent. 3) Among the tuberculin positives, all patients should be X-rayed and those with abnormal chest X-rays referred to the local health department or a chest specialist for further follow-up and diagnosis, or the physician may wish to undertake the further diagnosis of tuberculosis himself. It is common practice for patients who have abnormal chest X-rays but negative work-up for tuberculosis to be considered in the High Risk Register by the Health Department and placed upon prophylactic therapy, usually with more than one drug. This may be done by the health authority or by the physician after the diagnosis of active tuberculosis has been excluded. The reason is that it has been well established that persons with abnormal chest X-rays have a much higher risk of developing tuberculosis than those with normal chest X-rays. 4) All patients under 5 years of age who have a positive tuberculin should be put on prophylactic therapy for one year. 5) All patients with a tuberculin reaction of 15 mm or greater on the intradermal test or 5 mm or more on the multiple puncture test should be placed on prophylactic therapy for one year. 6) All patients with a definite but lesser reaction should be re-tested a year later and the rules outlined above followed. 7) In areas where a large percentage of the population reacts to one of the atypical mycobacterial antigens it may be desirable to perform these tests simultaneously with the tuberculin test. However, at least in certain areas of the country the presence of reactions to the atypical mycobacteria does not seriously interfere with the above program.

Summary

A simple and effective program for tuberculosis control, including prophylaxis, among the patients of an average general practitioner has been outlined. It is to be remembered that in most practices the prevalence of tuberculin reactors will not exceed 5 to 10 per cent and indeed may well be less than this since they tend to group into families. Tuberculosis control and prophylaxis is, therefore, in the range of a feasible office practice for a busy practitioner.

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Avoidance of Certain Pitfalls in Vaginal Cytologic Diagnosis

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Certain pitfalls in the interpretation of vaginal cytology can be avoided by the utilization of some basic principles in obtaining the specimen, supplying the pathologist with adequate clinical information, and biopsying all visible lesions.

THE IMPORTANCE of doing vaginal cytology on every female patient cannot be over-emphasized. In addition, a repeat smear at least at yearly intervals is necessary. Smears showing any atypia, however minor, should be repeated more frequently. It is our conviction that if these recommendations were universally followed, invasive cervical carcinoma could be abolished. It is unfortunate that cytologic examinations are not universally practiced. It is important, however, to bear in mind and to understand certain pitfalls and limitations of the test. We propose to discuss some factors that influence cytologic interpretation with suggestions for their solution and application to patient care.

Methods of Obtaining Cytologic Material

In attempting to diagnose malignancy of the female genital tract one may:

a. Collect a specimen from the posterior vaginal fornix with a spatula or by aspirating with a plastic or glass tube.

b. Scrape the portio of the cervix, especially the immediate area of the external os.

c. Aspirate from the endocervical canal.

Each method has its advantages and disadvantages. Of more importance, they serve to complement each other so that a combination study yields a maximum percentage of positive diagnoses. It has been demonstrated that the vaginal pool specimen does not yield as high a percentage of positive diagnoses for *in situ* carcinoma as is possible by cervical scraping. However, the pool specimen may demonstrate endometrial cancer cells more frequently. The endocervical aspiration may be especially valuable to detect the *in situ* lesions that often occur high in the endocervical canal in older women. In addition, such aspiration may be particularly effective in detecting early endocervical adenocarcinoma or a similar lesion of the endometrium.

The Problem of Prior Cautery

One of the most critical factors in the management of cervical lesions is the establishment of the correct diagnosis. Cauterization preceding any diagnostic procedure is to be condemned. This applies with equal force when utilizing cytodiagnosis. For example, a "planned" cauterization should not be done immediately following the obtaining of a specimen but should await the cytology report. Should the cytologic report be positive further studies will be rendered less accurate, or impossible, due to the destructive effects on the epithelium by the cautery. In addition, should cauterization be employed before smears are taken, changes in cells can ensue that mimic malignancy. This may lead to needless consternation on the part of the physician, worry for the patient, and to the performance of useless diagnostic tests.

The Problem of Immediate Post-Partum Smears

We find no objection to the interpretation of smears at any time during pregnancy or at the six weeks post-partum checkup. There is a predictable pattern at those times which offers no problem to proper evaluation. Thus, it is common practice to study vaginal smears

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during pregnancy or in the puerperium in many institutions. On occasion a patient may be seen first when she is in labor and it may be necessary to perform a cytologic study in the immediate post-partum period. In such instances we have at times seen pseudo-malignant cells so confusing that we now interpret these examinations with great caution. Such cells may represent basaloid cells remaining following scraping off of superficial elements or may be of chorionic origin. Follow-up smears usually resolve the dilemma. If any atypism persists it must be explained by further studies.

The Problem of Visible Lesions

Cytologic examination of specimens from the female genital tract is primarily designed to detect cervical lesions that are "invisible" to the naked eye or at most present as "chronic cervicitis". Thus, the greatest value of cytology is the diagnosis of epithelial atypicalities such as dysplasia, carcinoma *in situ*, early invasive, or occult carcinoma. Such lesions usually present over a fairly broad area of the cervix and are either easily accessible to scraping or exfoliate readily. Indeed, in the past two decades the field of cytology has not only allowed clearer definition of early stages of neoplasia but has, in the course of such studies, given rise to a variety of heretofore unrecognized or unappreciated histological epithelial entities.

It is only logical that cytology has been utilized with success in the diagnosis of visible cervical lesions, such as invasive carcinoma. However, it cannot be stressed too strongly that the primary, and definitive, method for the diagnosis of visible cervical lesion is by means of biopsy. Unfortunately, cervical cytology may be negative in the face of a frankly ulcerating, invasive lesion. This has been observed by us on at least six occasions over a period of two years. Also, it is common experience for invasive cancers to shed fewer cells than their *in situ* counterpart. We believe that the following reasons are partly explanatory. First, an invasive neoplasm may be associated with an overlaying area of frankly necrotic tissue. Second, fairly large amounts of blood may dilute malignant elements. Third, exfoliation may not occur as easily due to increased cohesiveness among cells of infiltrating lesions.

To summarize, one should no more allow a visible cervical lesion to go without a biopsy than one would omit cervical cytology as part of a routine pelvic examination.

The Importance of Providing Adequate Information When Submitting a Cytologic Specimen

As can be surmised from the foregoing, it is mandatory that the requisition slip accompanying a cytology specimen contain information as to how the specimen was obtained, whether hormone or other therapy has been given, pregnancy status, if a lesion is present or suspected, patient's age, or other pertinent data, especially if related to an existing disorder or prior malignancy of the female genital tract. For example, knowledge of post-menopausal vaginal bleeding usually ignites a search for endometrial adenocarcinoma cells. Knowledge of menstrual irregularities may allow for hormonocytologic interpretation leading to better patient care.

Thus, the quality of the report is proportional to the smear taken plus the information supplied.

Summary

Certain pitfalls in the interpretation of vaginal cytology can be avoided by knowledge of the manner of taking the specimen and by information adequate for proper clinico-pathologic evaluation. The inherent difficulties in evaluating smears following cautery, in the immediate post-partum period, and in the presence of a visible cervical lesion have been stressed. The primary intention of the cervicovaginal smear is for the detection of "invisible" lesions of the cervix.

SPECIAL ARTICLES

Be Wisely Selfish†

DONOVAN F. WARD, M.D.*

Dubuque, Iowa

THIRTY-SIX years ago on another campus, I was in a situation similar to the one you Seniors are in tonight. I, too, was completing my basic studies and was anxious to get on with the practice of medicine. I had no false modesty, and I hope that you have none either. I knew then as you know now what was supposed to be known at that stage of a lifetime of learning the craft of medicine.



Doctor Ward

So, this much, then, you and I have in common. We share our profession; we share this hour and the memory of an earlier one. It may be that here the likeness ceases. For the world of medicine that you are a part of is vastly different from the one I entered. It is a difference that sets you apart not only from my class, but from those classes which left here even a short five years ago.

I am sure you've heard the statistic, medicine has made more progress in the past 20 years than in the previous 2,000. There is reason to believe that its progress will be just as dramatic in the next two decades. You are entering the field of medicine at an exciting time. And I am sure that my colleagues share my relief that there are some of you young sharpies who are about to join us and help out when the learning gets rough.

And it will be rough, of course. The need to keep up will become more acute, as discoveries burgeon in number and adaptability. Your armamentarium will be ever-changing. You will utilize only its center, as it were—part of it fading continuously into obsolescence while new material must be adapted immediately.

I think that Americans will see seemingly unbelievable medical miracles in the remainder of this century. Already researchers are working with organ transplants and artificial organs, synthetic skin, artificial muscles to power paralyzed arms and legs, plastic arteries and plastic bone parts.

I have strong faith in medical science and am convinced that some day we may develop electronic devices so that even the blind might read, the deaf might hear, and the mute might speak.

Yes, the future of medicine is almost unbelievable.

That is about all the predicting I care to undertake. But cutting it off here, I let you in on a secret that is not usually discovered until further along in your practice; this is that it is easier to tell what has already happened than what is going to happen!

But some things in medicine undergo no change. They are those eternal verities which belong in all lives and all professions. You have learned the science of medicine at the University of Kentucky. Now it is up to you to learn the art of medicine which, because this is now to be your life, is actually the art of living.

It begins with an awareness that the man makes the profession. The profession does not make the man. This realization is the greatest asset any physician can have. Conversely, a lack of it can make a failure, as a human being and as a physician, of the most technically skilled.

The man makes the profession! His integrity, his devotion, his honesty, his humility, all reflect good on him and on the entire field of medicine.

We know the biblical injunction, "to cast our bread upon the waters so that it might return to us a hundredfold." In other words, be wisely selfish. Give, give, give, and you will get much in return.

And so to you whom, I, as a colleague, have a right to demand that you do credit to our profession, I say, "Be wisely selfish."

Be so concerned about your success as a human being and as a physician that you give yourself entirely to those who need your care.

Be so anxious to be happy that you never take time from service to wonder whether you are happy. Rest assured you will be!

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* *Immediate past president of the American Medical Association*

† *Presented to the University of Kentucky Medical School Senior Day, Lexington, Kentucky, April 12, 1966.*

The man or woman who goes into medicine with the idea of security, prestige, or possible fame has picked himself one of the hardest assignments I know. For on that basis he will give only to a point; he'll be busy counting the returns; he'll deny his patients part of his precious time; and he'll feel terribly sorry for himself because the practice of medicine is withholding from him that happiness he so richly deserves!

And he'll probably laugh a little at some of his colleagues. He'll point out that their fees are too low, their hours are too long, their homes not pretentious, their interest in their patients so personal and deep that it can't be real. He'll feel sorry for them because they have become slaves to the profession and humanity.

And if he's lucky maybe some day he will ponder why it is that these "slaves" are beloved by their patients, respected by their colleagues, and mysteriously imbued with a joy of life that bewilders him.

Because these selfish slaves are so caught up in the bonds of love they have no time nor energy to be anything but happy and successful at the art of medicine and the art of living.

The dog food commercials say, "All you add is love." Perhaps we should have that printed on every tongue depressor, to remind us just what we're here for.

"All you add is love." And you're in big trouble if you don't add it. Or, as Osler put it, "We are here to add what we can to, not to get what we can from life."

Be selfish, in that wonderfully wise way. Any one of us can think of at least a few who have mastered the art of this kind of selfishness. We have a parent or a classmate, a teacher, a clergyman, a friend, who makes an art of giving of himself and who, as a direct result, is one of the happiest we know, and certainly one of the most successful in the things that count.

Be so selfish for the good life that you haven't a minute to yourself.

Get to the hospital for rounds a little too early; there'll be some help you can give to use up the time. Stay a little too long, so lunch is cut a bit in quantity. Ask just one more question of the patient, or give one more word of reassurance.

Be a little nosy. Get interested in people, and if you can help solve a problem, medical or otherwise, do it, even at a cost of time or effort or discipline to you.

I have found that those who pride themselves on keeping to themselves are usually concerned only with themselves. More hurt is created in the name of "laissez faire" than this world dreams of.

Become so selfish for a good life that you get wrapped up in your local and state medical societies and in the American Medical Association. Give them your time, your support and your criticism as you feel the necessity.

You do not have to run for an office, but support and encourage the best contender you can find. Modern medicine is medicine for the people, and it must thrive in an atmosphere of democracy. It must be organized to function properly and to disseminate scientific information. It cannot do these things unless all who join the profession remember their "civic duties" as citizens of this field.

They must remember, too, their duties as citizens of the nation. Our profession today stands on the brink of government interference, over which virtually every other modern nation has led its doctors to socialism.

And yet we hear our colleagues yammer that doctors should stay out of politics. This is like asking us to stay out of citizenship. I heard it well said just a few weeks ago that, the "physician who doesn't believe in politics is like the drowning man who doesn't believe in water."

I have little respect for the man of medicine who sees his obligations ending at the door to his ivory tower. If he is to give his patients the best medicine available, he must then fight to preserve his freedom to practice.

Nor should our political activity be limited to fighting what we are against.

Rather, it should be based on the fact that we are working partners with every other citizen of our community, our state, our nation. We have obligations to work at government. Nothing good will be accomplished without my support as a citizen. Nothing bad will get by unless I turn my head the other way. It might be well for you to keep in mind the words of one political observer: "Often the statesman and the saint think they're doing good—but ain't."

Be wisely selfish in your relations with your family. Demand happiness so strongly that you are the one who gives 100 per cent for the success of your marriage. You will find your spouse gives just as much.

Wives are vital to the physician's living, the art of medicine and of life. Wives, too, will have sacrifices to make, lonely hours while the husband-doctor is on a call, last-minute cancellations, the waiting.

Perhaps these words of Amy Vanderbilt best sum up the idea I am trying to get across: "The Bible tells us so often to give thanks—to praise God—and to acknowledge all His benefits. Surely it is not that God, like us, needs appreciation of His own well-being. It must be because He knows that when we learn to give thanks, we are learning to concentrate not on the bad things, but on the good things in our lives."

Those good things will never cease coming into the home that never ceases to give.

Remember, prosperity does not insure the good life. It is up to you to stun this cynical world and make it fashionable again to be skillful and generous with your skills. Applaud the artisan, whether he be surgeon or TV repairman. I ask that you seek out what is correct for you and leave conformity to the timid.

Follow your religion, don't drag it along behind you. Respect and help the public servant, be wary of the politician, and know well the difference between the two. Avoid gaining security at the cost

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Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
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- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: 3 to 6 months — 3 mg. (½ tsp.* t.i.d.)
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Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
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is a corker

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of self-respect. Above all, keep your sense of humor! Better yet don't just keep it; nourish it regularly, because you often will need it to lean on and it must be strong enough to hold you up. There might be another profession in which it is more important to be able to laugh at disappointments, but I don't know what it is. It has been said that, "life still remains a very effective therapist." I can only add that a chuckle every so often is the best tranquilizer.

Enjoy this profession you are now a part of! Enjoy your family! Really care about your patients! Get enthused! You can have a ball being physicians, and you can leave this profession in a better state than you found it, if you live it according to one simple and wisely selfish guide: Remember why we are on this earth, and remember the words, "As you have done it unto one of the least of these, My brethren, you have done it unto Me."

Kentucky Legislation Concerning Reporting of Abused Children

Russell E. Teague, M.D.*

Frankfort, Kentucky

IN a recent publication of The Child Welfare League of America, Inc., Marian G. Morris and Robert W. Gould state:

"In our country, where the child has been called the future, evidence is accumulating that large numbers of children are being neglected, starved, beaten, and senselessly murdered. So pressing is this problem that, early in 1962, the U. S. Children's Bureau gave it top priority. They are now engaged in developing legislation that would facilitate reportage and investigation of injuries inflicted on children, and in seeking better methods of extending protective services for children. Although protective services have been handled traditionally by voluntary agencies, the trend is now toward public agency coverage."

The 1964 Kentucky General Assembly passed protective legislation requiring the reporting in writing of physical abuse of children to local law enforcement officers, with a copy of this report to be submitted to the Department of Child Welfare.

Suggested legislation from the U. S. Department of Health, Education and Welfare was used as a guide in preparing the Kentucky legislation. Forty-seven states have passed child abuse laws, but Kentucky's is one of the stronger in that case reporting is mandatory and penalties are provided for failure to report.

The law also provides that anyone — physicians, osteopathic physicians, or other persons who suspect that a child under the age of 18 has been willfully injured by parent or guardian, "shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed." The law further provides that the physician-patient privilege and the husband-wife privilege" do not apply in these cases.

Questions have been directed to the State Health and Child Welfare Departments as to whether the act includes the reporting of deaths of children who have been killed by other than accidental means. The opinion of the Child Welfare Department's legal counsel is that the law is intended to cover all child abuse cases, including those in which injuries cause death.

Other questions directed to the two departments indicate some lack of knowledge of this legislation, and that reporting procedures are not clearly understood, and, in most cases, incorrectly followed.

Since the law has been on the books, the Child Welfare Department has received a limited number of reports of abused children. Even fewer reports have been submitted in writing to local police authorities with a copy to the Department, as provided by the law.

Both Doctor Russell Teague and Child Welfare Commissioner Maurice A. Harmon are deeply concerned about the obvious lack of compliance with the law.

It is virtually impossible to carry out the law's basic intent of protection of Kentucky's children without the cooperation of Kentucky's physicians and other interested persons. The Department of Child Welfare plans to establish a central file of all "battered child" cases occurring in Kentucky, so that the case of a parent charged with maltreatment of a child in say, Western Kentucky can be followed up regardless of his future residence throughout the state. Only in this way can full protective services be provided.

In anticipation of full cooperation in compliance with the law, the Department of Child Welfare is preparing plans for a more detailed investigation and follow-up on each individual case and, in addition, will continually assess the magnitude of the child abuse problem in Kentucky.

Submitted by Russell E. Teague, M.D., Commissioner, Department of Health and Child Welfare Commissioner, Maurice A. Harmon.



The Last Smile

IT WAS late in the evening when he came to the emergency room of the hospital unannounced after a trip of sixty miles riding on the back seat of the car of a kind neighbor. The staff man on call was notified by the junior intern who had examined him and authorized his admission.

He was seventy-eight years of age, undernourished, unclean and quite evidently suffering from severe and constant pain in his abdomen. Little was learned of his illness or his social background on the evening of admission because the pain of his intestinal obstruction was too distracting for prolonged and detailed questioning, and yet be humane. In the succeeding days, however, it was learned that he had lived alone for several years in a little shack on a small farm that he once had owned. His wife, long since estranged, was dead, and his two children had departed to seek their fortunes under more favorable circumstances. Their whereabouts were unknown and they could not be notified of his illness. Whatever his past had been he was now a social derelict.

The pain was not relieved by opiates; vomiting was frequent and there was no desire for food; he was confused most of the time and his co-operation was poor. Diagnostic studies were difficult. Efforts at relief were entirely futile so that the physician and the consulting surgeon who was on the service that month proceeded to prepare him as quickly as was expedient for abdominal exploration. This was done on the third day after admission. Obstruction in the small bowel was high, with matting together of upper abdominal structures due to what appeared to be a malignant tumor arising perhaps from the pancreas. It was impossible to attempt any curative surgery and the effort to establish a palliative bypass around the obstruction seemed of questionable value.

The severe pain was at least temporarily relieved and vomiting was less persistent or severe. Periods of rest were more frequent and satisfactory, but the depletion from prolonged illness was too severe to be repaired. There seemed no desire for food. His sensorium became more cloudy. None but the hospital attendants came to hold his hand, to reassure him or encourage recovery. He was alternately restless, noisy, belligerent, and with increasing toxicity, gradually lapsed into a quiet coma. For a week or more there was no response beyond an occasional unintelligible muttering, a grimace from pain and a feeble attempt to take small amounts of food or liquids.

The operative wound healed. The abdominal distension had decreased. The surgeon had no more to offer. It was on the tenth postoperative morning when the attending physician and nurse visited him that he seemed more alert and made some response. There was no indication of pain. There was a faint smile of recognition and a feeble "Thank you, Doc", but the period of consciousness was brief and before they left the room he was again quiet and asleep. The nurse called at 2:00 p.m. to say that he was gone.

No post-mortem was done because there was none to grant permission. His remains were removed and disposed of in the same manner he had been brought—by charitable neighbors. There was no remuneration for his hospital care because it was in that long past period when hospitals accepted a role of charity as routine and a reason in part for their existence. There was no thought of pay to the physician or surgeon—such service was a part of their creed.

The money that was collected that month has long been spent and those who paid mostly forgotten, but the "Thank you, Doc" has renewed itself as a fresh flower many times, and the wan smile has been a shaft of sunshine to brighten a thousand dark days during the thirty years that have passed.

They say that such service is to be no more. A kind and benevolent government has provided that the hospital is to be reimbursed and the doctor paid if we will but execute the proper forms—and we must do that too, lest we abrogate the rights of our patient. Rich or poor are provided for alike. There needs to be no professional courtesy to our colleagues, to nurses, the clergy or even kinfolks. All we have to do is fill out the forms and get paid—and we should make heaps much more money.

This is a momentous month. The gates open upon a new era. It will be a different and strange experience—not very welcome to most of us. We must be young and versatile enough to adapt.

They say it is progress so let's move along.

SAM A. OVERSTREET, M.D.

The Pharmaceutical Industry Besieged

SINCE Dr. James Lee Goddard was sworn into office on January 17, as commissioner of the Federal Drug Administration, both he and the FDA have received a great deal of publicity on television and in the national newspapers and magazines. There have been news items concerning the banning of drugs, the withdrawal of certain other drugs and critical commentary on testing methods and alleged misrepresentation in advertising. On top of all this there have been requests for investigations into what is considered the unreasonable expense of certain drugs.

The pharmaceutical industry in general has been besieged in recent months with less than favorable publicity in so for as the general public is concerned. It is quite possible that the FDA did need new direction and revitalization. However the recent extensive publicity given its negative reactions to certain drugs has placed the drug industry in an unfavorable light and completely overshadowed in the public's mind the tremendous contribution the pharmaceutical industry has made to the health of that same public.

Many of the drugs used daily by physicians in the treatment of both minor and major diseases have been developed by the drug industry in the past ten years. Patients and others often fail to consider that lives are being saved and others prolonged, and hospitalization often either prevented or shortened by the new drugs prescribed by their physician. When patients complain about the cost of a drug, the physician should take a little time and explain the amount of research and money required to develop a new drug. A free, strong and competitive drug industry is important to our country and an informed public is the best means of keeping the industry this way. The doctors are in a good position to educate the public in this respect.

There were 627 major new drugs available in the United States from 1942 through 1965 and about two-thirds of these were developed in the U.S.A. Of the new drugs developed in the United States, ninety per cent come from drug industry laboratories. Life expectancy in the United States has increased from 59.7 years in 1930 to 70 years in 1966, an increase of ten years in the span of one generation. This is a real accomplishment when one considers that it is estimated that mankind has had something like ten million generations on this earth. Although other factors such as public health measures, nutrition and sanitation have contributed to this greater life expectancy, better drugs have also played an important part.

As an example the death rate per 100,000 population from tuberculosis fell from 45.9 in 1940 to 4.3 in 1964. In 1956, when the tran-

quilizers first received widespread use, the mental hospital population decreased by over 7,-800. This reversed a trend of increasing hospital population which began when the first American public mental hospital was established in 1773. It is estimated that billions of dollars worth of man-hours are saved annually as the result of new drugs. The development of a single new drug is expensive both in time and money. It is estimated that research and development for a new drug costs about five million dollars, and taken on the average, five to six years for completion of the development program.

One of the little known activities of the drug industry is the production of so-called public service drugs. These are drugs that are produced without profit in the public interest for rare conditions such as botulism and rabies.

The medical profession expects the drug industry to operate in a responsible manner just as the FDA does. It is inconceivable that the present and past record of the drug industry in the United States could have been achieved by any widespread lack of responsibility. It is to be remembered that this record was achieved without absolute governmental regulation. This is a good time for the doctors to come to the defense of the drug industry and to point out to the public the tremendous contribution the industry has made to the health of the nation.

WALTER S. COE

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater leadership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

ORGANIZATION SECTION

Color TV Seminar, Guest Speakers Highlight KMA Annual Meeting

Sixteen prominent guest medical authorities and five closed circuit color television seminars will be among the highlights of the 1966 Kentucky Medical Association Annual Meeting at the Convention Center in Louisville, September. 20-22, according to Everett H. Baker, M.D., Louisville, KMA president.

One of the features of this year's meeting will be color television, originating at the University of Louisville Medical Center, and to be presented by Smith, Kline and French Laboratories in conjunction with the general sessions, Roderick Macdonald, Jr., M.D., Louisville, chairman of the Scientific Program Committee announced. The television panel participants will include both local and guest speakers.

Full information on speakers and program details will be included in the Annual Meeting (August) Issue of *The Journal*.

Among the scientific speakers, who have not been reported are, Joseph Edward Tether, M.D., Indianapolis, a guest of the Kentucky Eye, Ear, Nose and Throat Society. His topic will be, "Therapy in Myasthenia Gravis". Doctor Tether has been assistant professor of neurology on a half-time research basis, since 1952, at the Indiana University Medical Center. His other half-time work is devoted to diagnosis and treatment of myasthenia gravis.

Doctor Tether, a member of the Medical Advisory Board and the Myasthenia Gravis Foundation, has had numerous papers published on myasthenia gravis. Having received his medical degree in 1938, from Johns Hopkins, Baltimore, he is certified by the American Board of Internal Medicine. Doctor Tether's topic at the Thursday meeting of his host specialty group has not been announced.

Douglas W. Eastwood, M.D., Charlottesville, Va., professor and chairman, department of anesthesiology, University of Virginia School of Medicine, will be the guest of the Kentucky Society of Anesthesiologists, and will speak to that group Thursday afternoon on, "Postoperative Respiratory Management". His group topic of discussion at the Thursday morning General Session Color Television Clinic, will be, "Drugs, Their Actions and Reactions".

Doctor Eastwood was diplomate for the American Board of Anesthesiology, 1951, and secretary for Virginia Society of Anesthesiologists, 1961-64. He received his M.D. in 1943, and his M.S. in 1949, both from the University of Iowa. Doctor Eastwood is a member of the American Society of Anesthesiologists, and a member of several other anesthesiological groups.

The guest of the Kentucky Orthopedic Society, Howard H. Steel, M.D., Philadelphia, will speak at the general session, Wednesday morning on, "Hospital Acquired Infections". Doctor Steel, who is professor of orthopedic surgery, Temple University School of Medicine, and associate professor of orthopedic surgery at the graduate School of Medicine, University of Pennsylvania, will address his host group on Tuesday afternoon. His topic will be, "Manifestations of Skeletal Diseases in the Head and Neck".

He received his medical degree in 1945 and his M.S. in 1951, both from Temple University School of Medicine. Doctor Steel is chief surgeon of the Shriners Hospital for Crippled Children, Philadelphia. He is a member of the American Academy of Orthopedic Surgeons and a member of many orthopedic societies.

Eugene C. Klatte, M.D., Nashville, the guest of the Kentucky Radiological Society, will speak on, "Newer Techniques in Diagnostic Radiology", Wed-



Doctor Eastwood



Doctor Tether



Doctor Steel



Doctor Klatte

MEDICARE STATEMENT CANCELLED

Your Editors had planned to carry in the July issue in The Journal of the Kentucky Medical Association, a rather full description of how Parts A and B of Title XVIII, PL 89-97 (Medicare) would be operated in Kentucky. We were not able to do this at that time because regulations had not been agreed upon.

In the meantime, you have received a 32-page booklet from the government, which gives full details on how the two parts of Title XVIII will be implemented. Your Editors feel that to carry through with our original plans would constitute an unnecessary and somewhat expensive duplication in view of the material you received.

Moreover, The Journal would not be able to send you on time the expected modifications that are anticipated in a program of this magnitude. Should you need additional copies of this manual, please contact your local Social Security office.

nesday afternoon, September 21, at the General Session. Thursday afternoon, he will speak before his host group on, "Peripheral Venography and Diagnosis of Abnormalities of the Peripheral Venus System".

Doctor Klatte is professor and chairman of the radiology department at Vanderbilt University School of Medicine, Nashville. After his graduation from Indiana University in 1952, he became a member of several radiological societies and fraternities.

AMA Assumes Responsibility For Project Vietnam

Project Vietnam, a volunteer program for American physicians to provide medical care for South Vietnamese civilians will now be completely controlled by the American Medical Association. The project will be known as AMA Volunteers for Vietnam.

The announcement made by Percy E. Hopkins, M.D., chairman of the AMA Board of Trustees, reported the contract was signed with the State Department's Agency for International Development, (USAID). Administration was previously handled for USAID by the People-to-People Foundation, Inc. Three members of KMA were honored by AMA citations for working with Vietnamese civilians on this program at the interim held at Cumberland Falls in April. George F. Brockman, M.D., speaker of KMA House of Delegates, Greenville, served under the auspices of project Vietnam.

The new program provides for U. S. physicians to volunteer for work in South Vietnamese civilian hospitals, usually for a 60-day basis. Newly appointed AMA Volunteers for Vietnam field director is Malcolm Phelps, M.D., El Reno, Okla., who will be stationed in Saigon beginning July 1. Physicians interested in the program may write to AMA Volunteers for Vietnam, American Medical Association, 535 North Dearborn, Chicago, Ill., 60610.

Kentucky Part B Medicare Claims To be Processed in Lexington

The Metropolitan Life Insurance Company, "carrier" for Part B of the Medicare Program, (Title XVIII, PL 89-97), in Kentucky, has established an office in Lexington which will process all Part B Medicare claims in Kentucky, Paul I. Robinson, M.D., Rye, N.Y., vice-president and chief medical examiner of the Company announced.



Mr. Smith

The new office, which will handle no other Metropolitan business, initially expects to have some 80 new employees, and will be located at,

1218 Harrodsburg Road, (Suite 300)
Lexington, Kentucky

The phone number and area code:
606-233-1436

Mr. Donald R. Smith, New York, who has had 23 years experience in group claim work, will manage Metropolitan's new Lexington office, Doctor Robinson stated.

Mr. C. Warren Davies, Louisville, who had been in Kentucky for the past four years, associated with the Metropolitan program at General Electric, will be assistant manager in the new office.

The processing of all claim forms, including the issuance and mailing of benefit checks and statements, will be performed at the Lexington address.

Methodist and ARH Hospitals in Pikeville to Combine

Pikeville's two hospitals, the 150 bed Methodist Hospital and the 50 bed Appalachian Regional Hospital, were scheduled to merge on July 1 according to a release received at press time.

W. Ernest Elliot, chairman of the Board of Directors, said the two hospitals would be operated in separate buildings for about two years until they could be brought together under one roof.

Payment of the $492,410 mortgage held by the government on the ARH hospital will become the responsibility of the Methodist Hospital, the announcement said.

The Methodist Hospital was built in 1923. The ARH institution was erected about 1955 by the Miners' Memorial Hospital Association of the United Mine Workers of America. The ARH has operated the hospital for the past two years.



Principals at the 12th Trustee District meeting in Somerset enjoy a moment of relaxation. Left to right are: standing, Robert F. Long, M.D., Somerset, 12th District Trustee; seated, Everett H. Baker, M.D., Louisville, KMA President; Mrs. Robert J. Salsbury, Mt. Sterling, President of Woman's Auxiliary KMA; Carl Cooper, Jr., M.D., Bedford, director of KEMPAC Board; Stephen B. Kelley, M.D., Somerset, president of the Pulaski County Medical Society.

Five KMA Trustee Meetings Held To Discuss Medical Advances

Excellent attendance was recorded at the five KMA Trustee District meetings held in Kentucky, covering periods from May 25, to June 14. Brief reports on these meetings follow.

Twelfth Trustee District

Approximately 70 members attended the annual meeting of the Twelfth Trustee District, held May 25, in Somerset. Guest speaker was Everett H. Baker, M.D., Louisville, president of the Kentucky Medical Association, whose topic was, "The Challenge of 1966", Richard F. Greathouse, M.D., Louisville, also spoke at the dinner session, according to trustee Robert F. Long, M.D., Somerset.

The scientific program was presented by O. B. Murphy, M.D., Lexington, and Charles C. Smith, Jr., M.D., Louisville. KEMPAC speaker was Carl Cooper, Jr., M.D., Bedford. This meeting, as all Trustee District meetings, a part of the Association's Continuing Education Program, provided an opportunity for physicians to discuss advances in medical science.

Fifteenth Trustee District

The Fifteenth Trustee District meeting, held June 1, in Middlesboro, presented Everett H. Baker, M.D., Louisville, KMA president as speaker. Harold B. Barton, M.D., Corbin, also spoke at the dinner session, according to E. C. Sealy, M.D., London, trustee. Philip L. Fuson, M.D., Middlesboro, was in charge of local arrangements.

The mid-afternoon scientific program was shared by Harold E. Kleinert, M.D., and Grover B. Sanders, M.D., Louisville surgeons. Doctor Barton represented KEMPAC at the meeting.

Third Trustee District

Approximately 60 physicians and their wives attended the June 8 meeting of the third Trustee District held in Madisonville. Featured speaker was KMA President, Everett H. Baker, M.D., Louisville. District trustee, Gabe A. Payne, Jr., M.D., Hopkinsville, reported that Harold B. Barton, M.D., Corbin, shared the program.

Preceeding the after-dinner program, a scientific seminar sponsored by the University of Kentucky Medical Center was held. Speakers for the seminar were Ward O. Griffen, M.D., associate professor, department of surgery, and John W. Schaefer, M.D., assistant professor, department of medicine, both from the University of Kentucky School of Medicine, Lexington. Also planned was a brief presentation by a representative of KEMPAC. Faull S. Trover, M.D., Madisonville, assisted with arrangements for the meeting, held at the Madisonville Country Club.

Fourth Trustee District

The Fourth Trustee District meeting, held June 9, in Elizabethtown, presented speaker Everett H. Baker, M.D., Louisville, president of the Kentucky Medical Association. The after-dinner program, planned by district trustee, Hensy S. Spalding, M.D., Bardstown,

was shared by Carl Cooper, M.D., Bedford.

The scientific program scheduled Sidney G. Marcum, M.D., and Samuel H. Cheng, M.D., both of Louisville. The 13 counties making up the district enjoyed a social hour after dinner.

Sixth Trustee District

Rex E. Hays, M.D., Glasgow, trustee for the Sixth District, said that approximately 60 members and their wives attended the District's third meeting of the year at Bowling Green, June 14.

KMA President, Everett H. Baker, M.D., Louisville gave the major address of the evening and Daryl P. Harvey, M.D., Glasgow, Board member for the Kentucky Educational Medical Political Action Committee, discussed the KEMPAC operations as a part of the program. Arrangements for the meeting were made by Paul Parks, M.D., Bowling Green.

Health Department's Recommendations Expanding Medical Assistance Program Approved by Governor's Advisory Council

The Governor's Advisory Council for Medical Assistance, in session on Monday, June 13, approved recommendations presented by the Division of Medical Care, State Department of Health, for expansion and revision of benefits for all providers of service in the Kentucky Medical Assistance Program. The expanded program, incorporating the implementation of Title XIX, PL 89-97 (Medicare), went into effect July 1.

Included in the "Recommendations for Expansion of Physicians' Benefits" was the approval of the accompanying chart establishing units of relative value for services performed with a conversion factor of $5.00 for specialists and $4.00 for all other physicians. The report defines a specialist for purposes of payment in the program as a physician certified as a diplomate of any of the medical specialty boards recognized by the Association of American Specialty Boards or designated as a fellow in the American College of Physicians or the American College of Surgeons.

According to the KMA Technical Advisory Committee on Indigent Medical Care chairman, Claude C. Waldrop, M.D., Williamstown, the members of the Governor's Advisory Council approved a liberalization of benefits concerning consultation fees. The details covering qualifications for payment of the $20.00 fee under this category were not available at time of this writing. (See last item listed on chart of benefit schedule).

The physicians' charges and the program's payment, is composed of three elements: (1) a basic professional service fee, (2) supplemental professional service fees (where applicable) and (3) ancillary service charges (where applicable). Supplemental and ancillary charges are considered incremental additions to the basic professional services charged according to the report approved by the Council.

The recommendation states that, "It is to be emphasized that this initial program of benefits is *not* assumed to be comprehensive in nature nor is the nature of the payment provisions for such care intended to establish precedence for the inhospital physicians' care benefits ultimately to be adopted by the program. It is presumed that future program expansions will be directed toward eventual full coverage of physicians' care rendered in hospitals on the basis of reasonable charges. It is acknowledged that the present proposed benefits are only an interim set of provisions which constitute an introduction by the program into this area."

The Governor's Council, whose chairman is G. L. Simpson, M.D., Greenville also approved a revised and simplified billing statement for use in the program.

For additional information, write to the Division of Medical Care, Kentucky Department of Health, 275 East Main Street, Frankfort.

Recommended Physician Benefit Schedule
Kentucky Medical Assistance Program
To be Implemented July 1, 1966

	Units of Relative Value	Service	Program Fee*	
		OUT-OF-HOSPITAL CARE		
Basic Services	2.0	Initial Visit	$ 8.00	($10.00)
	1.0	Subsequent Visit	$ 4.00	($ 5.00)
	3.0	Intensive/Extensive Service	$12.00	($15.00)
Supplemental Services	1.0	Emergency After Hours Care	$ 4.00	($ 5.00)
	1.0	Out-of-Office Care-Under 10 miles	$ 4.00	($ 5.00)
	2.0	Out-of-Office Care-10-19 miles	$ 8.00	($10.00)
	3.0	Out-of-Office Care-20 + miles	$12.00	($15.00)
		HOSPITALIZED INPATIENT CARE		
	10.0	Attendance Fee	$40.00	($50.00)
	5.0	Specialist Consultation Fee	—	($25.00)
	2.0	Radiologist/Pathologist Fee	—	($10.00)
	**5.0	"Other" Consultation Fees	$20.00	—

*The fees generally payable by the Program are based on a conversion factor of $4.00.
The figures in parentheses, based on a conversion factor of $5.00, are applicable when the service is performed by a specialist.
**See explanation in third paragraph of accompanying article.

AMA Board Recommends Changes In Life Insurance Programs

The AMA Board of Trustees met recently to study the existing program of the American Medical Association Group Disability Insurance Program. The present insurance program, which expires August 31, 1967, is not expected to continue with the same carrier.

The Board authorized F. J. Blasingame, M.D., executive vice-president, to investigate the possibility of procuring another carrier. The AMA's actuary was also given authorization to study the existing program and make recommendations for revising it.

Percy E. Hopkins, M.D., chairman of the AMA Board of Trustees, also reported to the House of Delegates at their June meeting that the AMA was exploring the possibility of purchasing group life insurance. The purpose of this program is for AMA members to have the opportunity to supplement their regular life insurance coverage.

UK Med Students Offered Assist By Loan Fund, Cancer Society

The U.S. Department of Health, Education and Welfare has granted the University of Kentucky, Lexington, nearly $150,000 for operation of a Health Professions Student Loan Fund during the first half of 1966-67. With the University's required contribution, the loan fund will total $166,532, according to Ordie Davis, program director of Student Financial Aid.

This will be the third year of loan assistance for students in the College of Medicine, Dentistry, and Nursing; and the first year for the College of Pharmacy.

The University of Kentucky was also recently awarded ten grants, totaling $55,479, by the American Cancer Society, Kentucky Division. Two of the grants are designated for research and the remaining eight will be given for the support of clinical fellows, according to Charles E. Tucker, executive vice-president of the Society.

KMA Adds Three New Members

Two Louisville physicians have been added to the KMA membership roster, according to the membership department during the month of June. The two which were enrolled are: Sergio Palacio, M.D., and John Urton, M.D. J. W. McClellan, M.D., Henderson, was also added as a member.

Digest of the Minutes of the Board of Trustees

April 12 and 13, 1966

After covering the necessary announcements for the two-day meeting and the routine reports, the Board considered a recommendation from the committee to Study Medical Practices in the ARHI institutions.

The Board of Trustees then considered the nominations for members of the Board of Directors for the Kentucky Educational Medical Political Action Committee and made its selections.

Paul I. Robinson, M.D., Rye, N.Y., vice president and medical director for the Metropolitan Life Insurance Company of New York was introduced by chairman Hubert C. Jones. M.D., Berea. Doctor Robinson explained how his company happened to be named the carrier for Kentucky under PL 89-97, Title XVIII, Part B. It was indicated that many of the regulations had not been formed at that time, and he was not able to give the full story on how the medicare plan would be implemented in Kentucky. He answered a number of questions.

The Budget Committee made its report for the proposed 1966-67 budget. It was explained that the Budget Committee had spent a day in preparation of the budget and that the Executive Committee had devoted a considerable amount of time to it. It was pointed out that there were no radical changes proposed for the new budget. After consideration, it was adopted.

Recommendations of the KMA Hospital Committee relating to area-wide planning were approved. Consideration of the location of the 1967 Interim Meeting was left up to the Executive Committee. Recommendations of the KMA Technical Advisory Committee on Indigent Care (which related to the implementation of PL 89-97, Title XIX in Kentucky) were debated at great length and eventually approved. At the same time, the Board voted to resist the so-called "preventicare" proposal.

The Ad Hoc Committee to Study the Council and Committee Re-Organization report was made, carefully considered and approved. In addition, a motion to continue the committee and enlarge its personnel and broaden its responsibility passed. The Board disposed of a matter relating to the orientation course and heard a report on the developments of PL 89-239, the heart, cancer and stroke program.

Kenneth P. Crawford, M.D., Louisville, who had attended the AMA Conference on Voluntary Health Associations at the request of KMA, gave a report of the meeting to the Board.

A series of recommendations from the Council on Legislative Activities was presented. It was voted to advise the membership that the individual was not required to sign the statement of compliance. A report on the 1966 Kentucky General Assembly was heard together with comments on strengthening

(Continued on Page 594)



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Vitamin B_{12} Crystalline	4 mcgm
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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(Continued from Page 592)

the KMA Legislative Key Man system. The Board voted to resist the efforts of the Department of HEW in the policy of using "generic equivalent drugs".

The Report of the Ad Hoc Committee to Study the publishing of a KMA directory was made, considered at great length, and it was decided to have the committee to continue studying the matter and come back with a firm proposal. The special Ad Hoc Committee of KMA to Study PL 89-97, Tit'e XVIII, Parts A and B, reported to the Board. The recommendation of the committee that KMA cooperate with the Kentucky Hospital Association and the Kentucky Blue Cross in seeking to use computers to aid utilization review committee work was accepted.

The Board also voted to ask the KMA Insurance Review Board to be the state-wide arbitration group to cooperate with the Metropolitan Life Insurance Company, the carrier under Part B. After full discussion of the financial problems facing the AMA, the Board voted to authorize the KMA Delegates to the AMA to support the increase in dues.

The Board approved the request of the University of Kentucky Department of Community Medicine relating to use of medical students in a summer research program, authorized the study of coverage for possible liability which might accrue to certain agencies, voted to accept the letter from Carroll L. Witten, M.D., Louisville, withdrawing from the race for vice-speaker of the AMA House of Delegates, and approved the request of health commissioner Russell E. Teague M.D., to name representatives on the laboratory advisory committee and took action on a number of special dues requests.

It was decided that the date of the next meeting would be Wednesday and Thursday, August 3 and 4.

Doctor Townes Receives Award

C. Dwight Townes, M.D., professor of opthalmology at the University of Louisville Medical School, was honored June 2, in Louisville, with the distinguished-alumnus award of the University's Hospitals Alumni Association. Although retired as chairman of the school's department of opthalmology, Doctor Townes expects to remain teaching and doing research in the Kentucky Lions Eye Research Institute.

RR Board Names Medicare Handler

The Travelers Insurance Company of Hartford, Conn., has been named by the Railroad Retirement Board as the intermediary for handling claims of railroad employees and annuitants under the medical insurance part of the medicare program.

The company will receive and pay bills for physicians' services and other medical services covered by the medical insurance plan for all qualified railroad employees and members of their families, as well as for railroad retirement beneficiaries.

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Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy

(Continued from Page 572)

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(Continued from Page 574)

which was the 11th neonatal day. The original impression was tracheo-esophageal fistula because of the dysphagia and mucous accumulation in the pharynx. A diagnosis of tetanus was based on the findings of regidity of the back and abdominal muscles, stiff extremities, tetanic spasms, and inability to open the mouth. There was a history of an oozing umbilical stump, however, no cultures for C. tetani were obtained initially and subsequent cultures were negative. Management consisted of the administration of human hyperimmune globulin, antibiotics, tranquilizers and sedation. All fluids and medications were administered parenterally and nothing was given orally after the second hospital day. In addition, the infant was kept in a quiet room with constant nursing care and the medical management administered by one physician. The infant survived and has completely recovered.

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TB Conference Set for Oct. 12-14

The Mississippi Valley Conference on TB is scheduled to meet in Louisville, October 12-14, on board the Belle of Louisville, according to James F. West, co-chairman of the program committee. The program will get underway with an early morning breakfast, followed by round-table discussions, and a public health session on "Realistic Statistics", during which the speakers will be introduced.





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Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Meprotabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

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ACR Group Favor Billing Change

Partial returns from a poll sent late in May by the American College of Radiology, Chicago, to approximately 5,800 ACR members show that most radiologists practicing in voluntary hospitals favor separate billing to patients. ACR Board Chairman, J.E. Miller, M.D., Dallas, reported that more than a third of the members have already made arrangements for separate billing.

By the close of 1966, more than half of the American radiologists practicing in voluntary hospitals are expected to begin sending their own bills to patients, according to the survey. In addition, the Health Insurance Council, representing the commercial insurers, has reaffirmed its intent to provide coverage based upon the way services are billed.

Doctor Massie Receives Award

Francis M. Massie, M.D., Lexington, received one of four distinguished service awards presented by the University of Kentucky Alumni Association at the annual May reunion banquet in Lexington. Doctor Massie, one of the founders of the Kentucky Medical Foundation, was the first non-alumnus of the University to receive the Association's award.

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Bicentennial Observed in Conn.

The 200th year of the founding of the Litchfield County Medical Association of Connecticut will be commemorated June 20, at Lakeville, Conn. G. S. Gudernatch, M.D., chairman, said, "According to available records, ours is the oldest county medical association continually in existence in America."

Originally named the Litchfield County Medical Corporation, the group was formed to promote professional standards in medicine. A part of the June program will be the presentation of honorary degrees of medicine rarely conferred in this country.

Flying Physicians Meeting Set

The 12th. annual meeting of the Flying Physicians Association will be held at the Dunes Hotel, Las Vegas, September 11-16, according to George M. Gumbert, Jr., M.D., Lexington, secretary of the association. Doctor Gumbert stated that the scientific sessions will consist primarily of discussions on medical disciplines as they relate to aviation in general.

Medicare Premium Notices Sent

Approximately two million elderly people out of the total of 17 million that have enrolled under part B of the Medicare Program will receive, during June, a premium notice for the voluntary medical insurance benefits. Premiums on the remaining 15 million will be deducted from their Social Security benefits.

According to Social Security Commissioner, Robert M. Ball, the premium will be billed on quarterly basis: three months at $3 per month or $9 per quarter. Mr. Ball stated, however, that those who could not manage the quarterly payment may pay $6 for two months' coverage or $3 for one months'.

Diabetes Assn. to Meet Sept. 19

The fifth annual scientific meeting of the Kentucky Diabetes Association will be held September 19, 1966, at the Kentucky Hotel, in Louisville, according to John B. Selby, M.D., KDA Medical Service. Among the speakers will be Wallace McMeel, M.D., a Boston opthamologist, and Rafael A. Camerini-Davalos, M.D., New York City.

The meeting will begin with the scientific program, followed by a luncheon and afternoon panel discussions. Doctor Selby stated that a more complete schedule of the program, open to physicians and interested persons, will be made known at a later date.

ACP Fellowship Inducts 2 Ky. M.D.'s

Billy F. Andrews, M.D., and William R. Gray, M.D., both of Louisville were inducted into Fellowship of the American College of Physicians at its recent meeting, according to Carl H. Fortune, M.D., Lexington, the College's governor for Kentucky.

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Contraindications: Contraindicated in patients sensitive to sulfa or penicillin, pregnant females at term, premature infants, newborns during first week of life. **Precautions:** Watch for hypersensitivity reactions and overgrowth of nonsusceptible organisms. Observe usual precautions for sulfonamide therapy: adequate fluid intake; force fluids if urine volume is low; maintain urinary pH of 7 or higher; use only after critical appraisal in patients with liver or renal damage, urinary obstruction, blood dyscrasias. **Adverse Reactions:** Anaphylactoid shock (rare), G.I. disturbances, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, urticaria, purpura, hematuria, crystalluria, conjunctival and scleral varicula, petechiae may occur. **Dosage:** Daily pediatric dosage should supply 65-100 mg. trisulfapyrimidines per pound body weight in divided doses q. 4 to 6 h. **Supply:** Pentid-Sulfas for Syrup when prepared, provides 80 cc. (16 doses) or 150 cc. (30 doses) of fruit-flavored syrup providing in each 5 cc. teaspoonful 125 mg. (200,000 u.) potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine.

Now . . . **NEW PENTID® '400'—SULFAS FOR SYRUP** (buffered penicillin powder with sulfadiazine, sulfamethazine, and sulfamerazine each 5 cc. providing 250 mg. [400,000 units] potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine). Available in 16-dose (80 cc.) and 30-dose (150 cc.) bottles.

For full information, see Product Brief.

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NEWS ITEMS

Don Chatham, M.D., Shelbyville, has returned from Africa, where he had spent three weeks in order to give the regular doctor a vacation. Doctor Chatham is the surgeon for the Southern Railway in Shelby County.

Franklen K. Belhasen, M.D., Paintsville, has opened an office, practicing in association with F. M. Picklesimer, M.D. Doctor Belhasen, who is in general practice, was graduated in 1964 from the University of Kentucky Medical School and interned at Wilford Hall, USAF Hospital, during 1965. He served in the USAF for two years maintaining the rank of Captain.

Homer B. Martin, M.D., Louisville, has moved to Baltimore, Md., where he will complete his residency in psychiatry in the coming year. Doctor Martin's address is The Sheppard and Enoch Pratt Hospital, Towson, Md.

Robert R. O'Connor, M.D., formerly of Asheville, N.C., has opened an office in Louisville, where he will specialize in psychiatry as an associate of Patrick P. Galla, M.D. Doctor O'Connor was graduated from the University of Louisville Medical School in 1962 and interned at St. Joseph's Infirmary.

H. E. Erausquin, M.D., Paris, presented his resignation, June 6, 1966, as a member of the Bourbon County Medical Society. Doctor Erausquin is leaving Kentucky for San Francisco, Calif., where he will resume his practice.

Russell Rudd, M.D., Fulton, was recently chosen as president of the Southwestern Kentucky Medical Association, at its 77th annual meeting held in Paducah. Doctor Rudd will take office for the year 1967.

S. Pearson Auerbach, M.D., Louisville, was appointed by Governor Edward T. Breathitt as a member of the Commission for Handicapped Children for a term ending July 1, 1967. Doctor Auerbach will succeed the late Charles F. Wood, M.D., Louisville, who was serving his second term on the Commission.

William W. Adams, M.D., Lexington, will be temporarily terminating his practice in order to return to medical school. He will specialize in obstetrics and gynecology while a resident at Homer G. Phillips Hospital, St. Louis, Mo.

Grace M. James, M.D., former Louisville pediatrician, has been appointed, effective July 1, to head the diagnostic and evaluation division of Frankfort State Hospital and School. Doctor James has recently completed post graduate work in child psychiatry at Creedmoor State Hospital and Albert Einstein College of Medicine, both in New York.

(Continued on Page 602)

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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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(Continued from Page 600)

Ahmet Hamdi Yilmaz, M.D., Louisville, will soon be leaving for the Hawaii State Hospital, Kaneohe, Hawaii, where he has accepted a position as Staff Psychiatrist. Doctor Yilmaz had been practicing at the State Tuberculosis Hospital, Louisville.

COUNTY SOCIETY REPORTS

McCracken

The regular May meeting of the McCracken County Medical Society was held at Boswell's Restaurant, Paducah. A program on the support of the Kentucky Educational Medical Political Action Committee was presented by Richard F. Greathouse, M.D., Louisville, secretary-treasurer of KEMPAC and vice-speaker of the KMA house of delegates. Doctor Greathouse also spoke of the need for men of medicine to unite politically.

Following his address, Walter R. Johnson, Jr., M.D., Paducah, Society president, presided over the business meeting.

The old business concerned information on Medicare, to be secured by secretary Frank B. Crawford, M.D., Paducah. As Doctor Crawford had requested, KMA headquarters forwarded all available material. This literature will be kept on file for future reference. Committee reports were then given, after which followed a report on correspondence. In response to a letter from Everett H. Baker, M.D., Louisville, KMA president, representatives were appointed to attend the June 15 meeting in Louisville, presented by the Metropolitan Life Insurance Company.

New business concerned the appointing of a Memorial Committee to oversee Society procedures taken at the time of death of local physicians. The final act of business was the discussion of a suggestion from Rodney Fields, M.D., neurosurgeon of Memphis, Tenn. Doctor Fields offered to fly to Paducah one day each week to see cases at either local hospital, in consultation at the request of the attending physician. The Society looked upon this endeavor with favor.

Following is a list of recently reported county medical society officers. Others will be listed in August.

Anderson

President Boyd H. Caudill, M.D.; secretary, R. N. Lawson, M.D.; delegate, Doctor Caudill; alternate, G. F. Gilbert, M.D. All are from Lawrenceburg.

Boyle

President, James W. Ramey, M.D.; vice-president, Robert Fowler, D.D.S.; secretary-treasurer, Philip R. Rothrock, M.D. All are from Danville.

Casey

President, Lewis E. Wesley, M.D.; vice-president, George W. Sweeney, M.D.; secretary, Woodrow Lester, M.D.; delegate, Garnett J. Sweeney, M.D.; alternate, Doctor Wesley. All are from Liberty.

Clark

President, Garland H. Clark, M.D.; secretary-treasurer, Thomas E. Averitt, M.D.; delegate, Harold S. Moberly, M.D.; alternate, Doctor Averitt. All are from Winchester.

Daviess

President Reginald J. Phillips, M.D.; vice-president, James H. Callis, M.D.; secretary-treasurer, James A. Baumgarten, M.D., delegates, Doctor Phillips and William W. Hall, M.D., alternates, Duncan G. Johnson, M.D. and William A. McManus, M.D. All are from Owensboro.

Harrison

President, C. L. Thornberry; vice-president, H. T. Smiser; secretary-treasurer, Don R. Stephens, M.D., delegate, Henry H. Moody, M.D.; alternate Doctor Stephens. All are from Cynthiana.

Marshall

President, Wendell E. Gordon, M.D.; vice-president, Keith E. Ellis, M.D.; secretary-treasurer, H. W. Ford, M.D.; delegate, Doctor Gordon; alternate, Doctor Ellis. All are from Benton.

Metcalfe

Secretary, L. P. Emberton, M.D., Edmonton.

Monroe County

President, John C. Marsh, M.D.; vice-president, J. E. Carter, M.D.; president-elect, J. J. Martin, M.D.; secretary-treasurer, W. F. Hunt, M.D.; delegate, W. R. Bushong, M.D.; alternate, K. R. Crabtree, M.D. All are from Tomkinsville.

Spencer

President, William K. Skaggs, M.D.; vice-president, J. T. Furnish, M.D.; secretary, Martin H. Skaggs, M.D.; delegate, Doctor William Skaggs; alternate, Doctor Martin Skaggs. All are from Taylorsville.

Trimble

President, John I. Cooper, M.D.; secretary, Carl Cooper, Jr., M.D.; delegate, Doctor Carl Cooper; alternate, Doctor John Cooper. Both are from Bedford.

Washington

President, Richard A. Hamilton, M.D.; vice-president, M. A. Coyle, M.D.; secretary-treasurer, Harold B. Simms, M.D.; delegate, Doctor Simms; alternate, Dixie E. Snider, M.D. All are from Springfield.

Wolfe

Secretary and delegate, Paul F. Maddox, M.D., Campton.

Woodford County

President, Benjamin F. Roach, M.D., Midway; secretary-treasurer, Olson Parrott, M.D., Versailles; delegate, Doctor Roach; alternate, Norman S. Fisher, M.D., Midway.

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In Memoriam

TRACY JONES, M.D.
Harlan, Ky.
1908-1966

Tracy Jones, M.D., 57, former Harlan general practitioner, died April 24, at his home in Long Beach, Calif. Doctor Jones, who received his medical degree from the Louisville School of Medicine in 1940, was associated with Douglas Aircraft Company in the plant medical service, Long Beach. He was a former president of Harlan Lions Club and the Harlan County Chamber of Commerce.

ADA Award Presented

Thomas J. Merimee, M.D., former Louisvillian, has been named recipient of a newly established American Diabetes Association Research and Development Award. Doctor Merimee, a graduate of the University of Louisville School of Medicine in 1955, is now associated with the department of medicine at Johns Hopkins University. His research objective relates to how metabolism in people with diabetes differs from normal metabolism.

Drug Safety — Who's Responsible? "Government, the physician, and the pharmaceutical industry must join forces to reduce injury from adverse drug reactions. It is industry's responsibility to continue with the development of safer and more effective drugs. It is the responsibility of the physician to use drugs with discretion and to abstain from using potent and hazardous drugs for trivial conditions. It is the government's responsibility, with its virtually unlimited funds and resources, to continuously review and survey adverse experience gained with drugs from all sources and to bring these facts before physicians preferably through already organized channels of medical communication. The government further has a responsibility to remove overly hazardous drugs from the market when usefulness does not balance off against hazard, but it must not use this authority in an arbitrary and capricious manner. The evaluation of drugs for safety is a most difficult and complex matter, and no simple formula can be divised to arrive at a conclusive opinion." Joseph F. Sadusk, Jr., M.D., to *American College of Physicians,* New York, April 19, 1966.

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September 20-22

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New
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Whenever tetracycline is indicated in these candidates for Candida:

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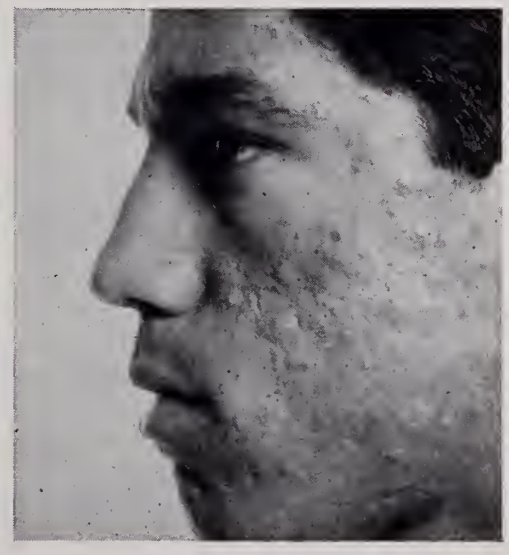
3. elderly or debilitated patients



. patients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule *q.i.d.* Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals. *Supply:* Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

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Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.

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KMA Council and Committee Reports

Council on Medical Education and Hospitals

George A. Sehlinger, M.D., Louisville, Presiding

KMA Headquarters Office — May 26, 1966

The KMA Council on Medical Education and Hospitals met for the third time this associational year on May 26.

Members of the council reviewed the final report of the five committees serving under the council and took appropriate action prior to forwarding the reports to the KMA House of Delegates. Also discussed by the council members was the library services available at the University of Louisville School of Medicine. Specific recommendations were made to call this facility to the attention of physicians in the state.

The council members also reviewed nominations for the 1966 KMA Faculty Scientific Achievement Award and selected the representatives for the award to be presented during the 1966 KMA Annual Meeting.

Disaster Medical Care Committee

William T. Rumage, Jr., M.D., Louisville, Chairman

KMA Headquarters Office — May 26, 1966

The KMA Disaster Medical Care Committee recently held its third meeting of the associational year and had a number of guests in attendance representing the allied health fields and other organizations interested in disaster medical care.

Considerable discussion was held in the areas of transportation of the injured, location of hospital signs on highways, first aid programs in schools and industry and dental disaster teams. The committee members are making recommendations that KMA urge the Kentucky Hospital Association to distribute a questionnaire to Kentucky hospitals asking for information about auxiliary power, communications and blood supply in disaster situations. The committee requests the KMA to approve the concept of annual registration of physicians in Kentucky.

Highway Safety Committee

John J. Robbins, M.D., Louisville, Chairman

KMA Headquarters Office — May 24, 1966

In this, its first meeting of the associational year, the Highway Safety Committee reviewed its purposes at the beginning of the meeting and reviewed the final report to the 1965 House of Delegates.

The primary discussion and action of the committee centered around the three-year report of the Automobile Crash Injury Research Program conducted by Cornell University, the Driver Limitation Program, the compulsory annual automobile inspection law, and greater promotion of the 100 percent seat belt award program. Members of the committee also wrote their final report to the 1966 House of Delegates.

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

KMA Headquarters Office — May 19, 1966

The Hospital Committee recently held its third meeting of the associational year at KMA Headquarters Office. Resolution A, entitled, "Administrative Relationship Between Hospitals and Private Practitioners of Medicine Practicing Within Hospitals", occupied the major portion of consideration by members of the committee. A report was received from the Hospital Sub-Committee to Study Resolution A to be included in the committee's final report to the 1966 House of Delegates.

Discussion of area-wide hospital planning was also held and it was the consensus of the members that there is not great interest among lay or medical people to continue its efforts at this time.

The committee formulated its final report to the House of Delegates covering the three meetings of the full committee in addition to the number of meetings of the Hospital Sub-Committee to Study Resolution A.

KMA Technical Advisory Committee On Indigent Medical Care

C. C. Waldrop, M.D., Williamstown, Chairman

State Department of Health — Friday, June 3, 1966

On June 3, 1966, the KMA Technical Advisory Committee on Indigent Medical Care met with Members of the Division of Medical Care in Frankfort to give further consideration to fees for physicians' services under Title XIX of PL 89-97, the Medicare Act.

A revised proposed "Physicians' Benefit Schedule" was presented by the Division, in order that the committee might review it.

The committee made a number of recommendations to the state agency consistent with instructions from the KMA Board of Trustees.

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"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function... Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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DACTILASE®

Each tablet contains:
Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
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Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

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In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

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For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.



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Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

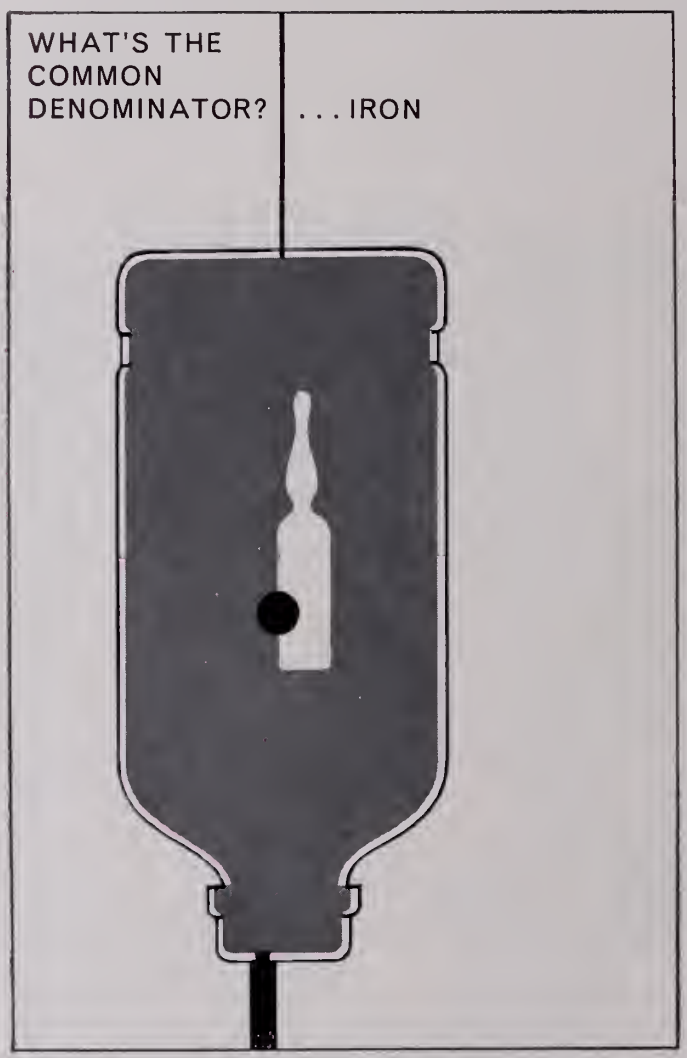
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IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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(trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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restores normal patterns of sleep and activity

Norpramin (desipramine hydrochloride) reverses the signs and symptoms of depression including sleep disturbances, feeling of sadness, guilt, worthlessness, anxiety and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, more active and less weighed down by their problems.

Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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ERYTHROCIN®-SULFAS

ERYTHROMYCIN ETHYL SUCCINATE–TRISULFAPYRIMIDINES



in chewable tablets

in granules for oral suspension

When combination antibiotic therapy is indicated...



CONSIDER: an exceptionally high cure rate in susceptible infections

The rationale: When combined, Erythrocin and the trisulfapyrimidines (triple sulfas) are indicated in infections that are more susceptible to the combination than to either agent alone. Such conditions are usually found in urinary, lower respiratory tract and chronic ear conditions.

The results: Clinical studies involving 142 young patients showed *an overall cure rate of 96.5%*. Side effects were experienced by only four of the patients.

The acceptance: The majority of the 142 patients studied expressed a definite liking for the products. *There were only two refusals.* An independent taste-test with 50 healthy children further substantiated the excellent acceptability of the orange-flavored forms.

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ERYTHROCIN®-SULFAS

ERYTHROMYCIN ETHYL SUCCINATE–TRISULFAPYRIMIDINES

In Chewable Tablets
In Granules for Oral Suspension



ERYTHROCIN®-SULFAS

Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

ABBOTT

AMA Presents '66 Jacobi Award

E. H. Christopherson, M.D., Evanston, Ill. executive director of the American Academy of Pediatrics, received the 1966 Abraham Jacobi Award presented by the AMA at their annual meeting in Chicago, June 27, for his dedication to the art and science of child care. Doctor Christopherson, also chairman of the Council of National Organizations for Children and Youth, Washington, D.C., received his M.D. degree from Washington University School of Medicine, St. Louis, in 1925.

Dr. Marshall to Present Paper

T. R. Marshall, M.D., associate professor of radiology, University of Louisville School of Medicine, will present a paper entitled "Radiographic Changes in Rheumatoid Arthritis", June 29 at the annual AMA meeting in Chicago.

Doctor Marshall has developed several new vascular techniques and has been a pioneer in the rapidly growing field of arteriography. He has published more than 50 papers pertaining to X-ray studies.

Fund Campaign Reaches $302,000

The building fund campaign at Good Samaritan Hospital, Lexington has reached nearly 25% of its $1,302,000 goal from pledges by the medical staff. M. Randolph Gilliam, M.D., Lexington, president of the staff complimented the generosity of each contributing member.

Collected funds will be used to purchase equipment for future needs of the hospital. The endorsement of the Good Samaritan Hospital's medical staff has added a considerable stimulant for more liberal giving.

Dr. Weldon Honored by 3000

William Adair Weldon, M.D., a native Hart Countian, received a special recognition in May by a crowd of 3,000 persons who came to honor him at the Glasgow High School for his 50 years as a doctor and humanitarian. Doctor John Burns Horton, president of Lindsey Wilson College, and State Treasurer Emerson (Doc) Beauchamp spoke in his behalf.

Doctor Weldon's wife was also present as he received awards and tokens from the community. An eye, ear, nose and throat specialist, he opened an office in Glasgow where he continues to practice with an associate.

Lancaster Seminar Held in June

The Lancaster Seminar of the Kentucky Academy of General Practice was held June 16, at the Garrard County High School, according to Paul J. Sides, M.D., Lancaster, program chairman. Five scientific papers were presented by essayists from Louisville and Lexington.

Gastroenterology Course Set

The annual course in postgraduate Gastroenterology of the American College of Gastroenterology will be given at the Bellevue Stratford, Philadelphia, Pa., October 27-29. A related session on instrument techniques will be held at the Albert Einstein Medical Center, Northern Division. For further information and enrollment, write to American College of Gastroenterology, 33 West 60th Street, New York, N. Y. 10023.

Dr. Mays Takes Post in Nigeria

E. Truman Mays, M.D., assistant professor of surgery at the University of Louisville School of Medicine, left July 1, for a Baptist missionary post in Nigeria. According to Doctor Mays, he will serve at the Obogomsho hospital with three other physicians for the next three years.

Doctor Mays will live on the hospital grounds with his wife and family. Before leaving, he was honored by the Lyndon Baptist Church on World Missions Day.

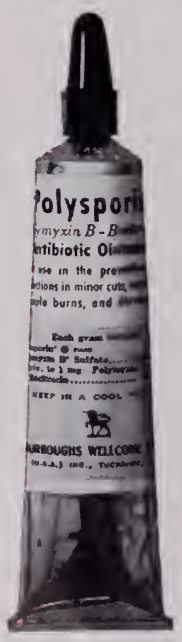
KMA Staff Member Resigns

Mr. Thomas M. Temple, a member of the KMA Executive Staff since January 1, 1965, recently resigned to accept employment with the New York Stock Exchange Firm of Stein Brothers and Boyce. The members and staff of The Kentucky Medical Association extend their best wishes to Mr. Temple for much success in his new endeavor.

In his letter of resignation to the KMA Executive Secretary, Mr. Temple stated, "I would like to say I have thoroughly enjoyed my work with the physicians in Kentucky, you, other members of the staff, and officers of the Association. The experience gaincd cannot be measured and for this I am deeply grateful. My relationship with all has been most rewarding."

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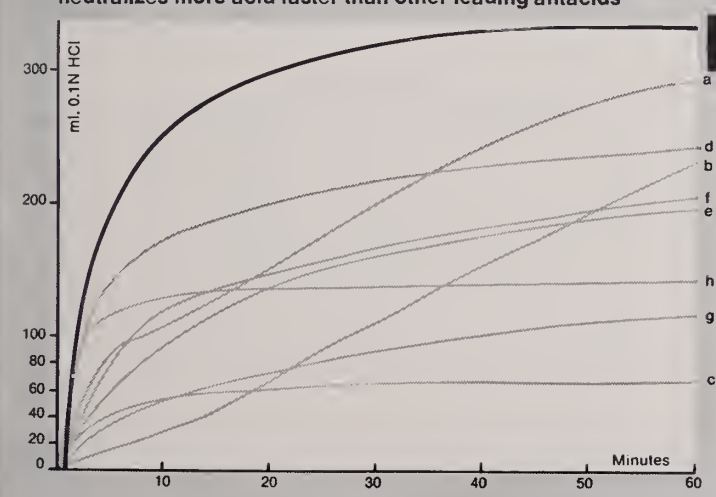
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MESSAGE FROM THE PRESIDENT



Ups and Downs

MAGAZINES and journals are filled with articles that tell stories of medicine, medical care, the patient and the physician. A graph of the physician's emotions would show plateaus more varied than recent market movements. The high peak was reached with the KMA July editorial of Doctor Sam Overstreet. An article in a recent issue of the *New Yorker* caused the opposite effect.

The latter article pointed out that physicians formerly spent all of their professional hours in advancing medical education and improving medical care to the patient. But now, so the writer continues, much money and time is being spent in the area of lobbying and legislation by the physicians and the AMA.

Why has it been necessary for the physician to work in the field of legislation? The answer should be simple. It is because legislators and such agencies as Health, Education, and Welfare have become interested in patient care, regional health centers and many other facets in the health field that were and are the responsibility of the physician. Should we not work with the executive branch, the legislative branch and their agencies to offer suggestions and set up guidelines that continued improvement in the health of every citizen may be maintained?

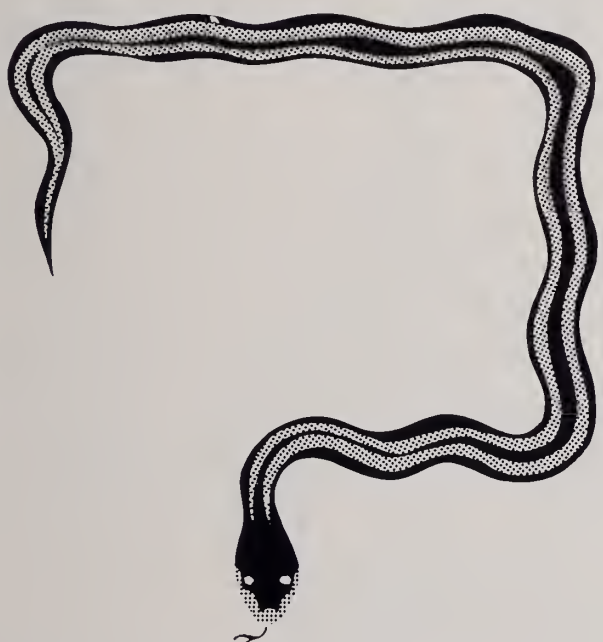
If we fail to meet our challenge, we will find decisions that have come about through political expediency. Furthermore, we will see people in high places because they are acceptable to a welfare organization, but who need orientation by those qualified to advise.

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Everett H. Baker

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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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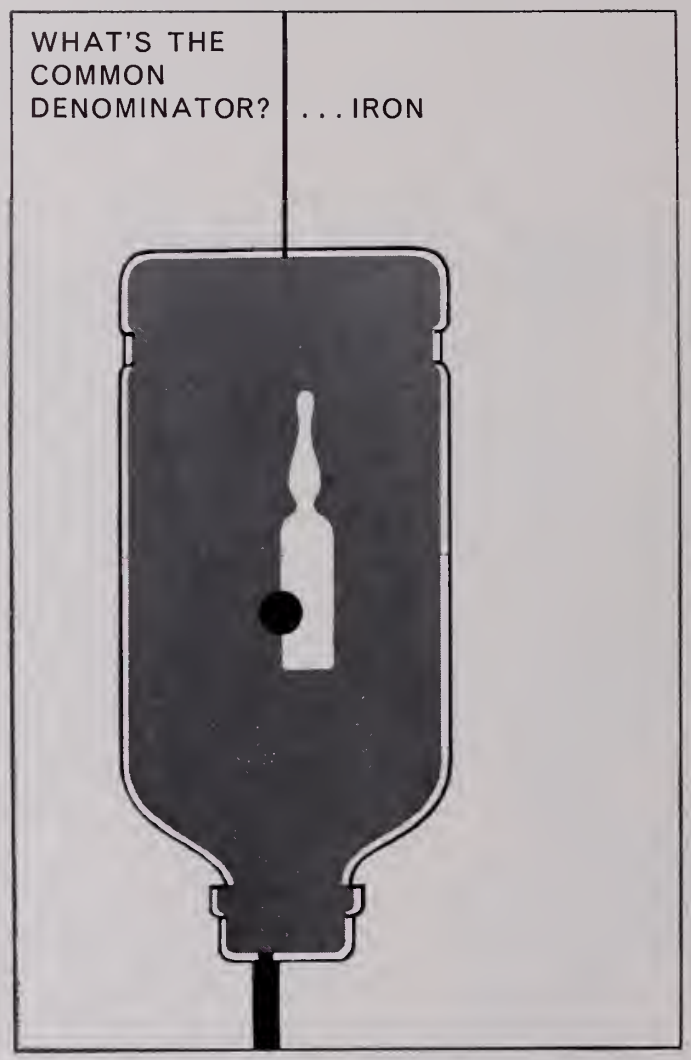
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SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

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Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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2 mg. or 4 mg. and
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Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

PRODUCTS FOR PATIENTS YOU SEE EVERY DAY LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

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each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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SEPTEMBER

9-10 "Cardic Emergencies", University of Kentucky College of Medicine, $30 registration fee.

9-10 KAGP Seminar, Kentucky Dam Village

20-22 KMA ANNUAL MEETING, Convention Center, Louisville

OCTOBER

6 KAGP Maysville Seminar, Health Department Office, Maysville

13-16 American College of Obstetricians and Gynecologists (ACOC) District V. Meeting for physicians and nurses, Stouffers Inn and Brown Hotel, Louisville

31-Nov. 12 PG Course in Otolaryngology and Bronchoesophagology, University of Louisville Medical Center

IN SURROUNDING STATES

AUGUST

25-27 West Virginia State Medical Association Annual Meeting, The Greenbrier, White Sulphur Springs

27-Sept. 2 American Congress of Physical Medicine and Rehabilitation and American Academy of Physical Medicine and Rehabilitation, joint meeting, Sheraton Palace Hotel, San Francisco

29-Sept. 1 American Hospital Association, Palmer House, Chicago

SEPTEMBER

5-12 Third International Congress on Human Genetics, University of Chicago

8-10 American Association of Obstetricians and Gynecologists, Hot Springs, Va.

11-16 Flying Physicians' Association, The Dunes Hotel and Country Club, Las Vegas

20-28 Tenth Congress of the Pan-Pacific Surgical Association, Part 1, Honolulu, Hawaii

25-30 Michigan State Medical Society Annual Meeting, Pantlind Hotel, Grand Rapids

26-27 Tennessee Valley Medical Assembly, Tivoli Theater, Chattanooga

26-30 AMA Association 26th. Congress on Occupational Health, Oregon Medical Association 92nd. Annual Session in conjunction with 13th. Annual Pacific Northwest Occupational Health Conference, Memorial Coliseum, Portland, Ore.

OCTOBER

1-2 American Academy of Pediatrics, Pocono Manor Inn, Pocono Manor, Pa.

1-5 American Society of Anesthesiologests, Sheraton Hotel, Philadelphia

7-14 American Academy of General Practice, War Memorial, Boston

7-8 Congress on Medical Quackery, Pick-Congress Hotel, Chicago

10-14 Annual Clinical Congress, American College of Surgeons, San Francisco

10-12 Indiana State Medical Association Convention, Sheraton Hotel, French Lick, Ind.

11-14 Pennslyvania Medical Society Annual Meeting, Pennsylvania Sheraton Hotel, Pittsburgh

15-16 American Association of Opthalmology, Palmer House, Chicago

16-21 American Academy of Opthalmology and Otolaryngology, Palmer House, Chicago

17-20 Interstate Post Graduate Medical Association, Sheraton Park Hotel, Washington, D.C.

22-27 American Academy of Pediatrics, Palmer House, Chicago

31-Nov. 4 American Public Health Association, Civic Auditorium, San Francisco

NOVEMBER

3-5 Southeastern Chapter of the Society of Nuclear Medicine, Durham, N.C.

6-9 Medical Society of Virginia Annual Meeting, Williamsburg Lodge, Williamsburg

9-11 Tennessee Academy of General Practice, (18th. Annual Scientific Assembly) Gatlinburg Auditorium, Gatlinburg

12-14 17th. Hahnemann Symposium on Renal Failure at Mariott Motor Hotel, Philadelphia

14-17 Southern Medical Association, Washington Hilton Hotel, Washington, D.C.

26-27 American College of Chest Physicians, Flamingo Hotel, Las Vegas

27-30 American Medical Association (Clinical Convention), Las Vegas

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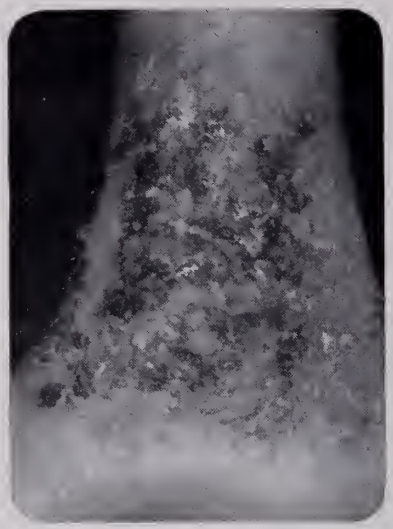
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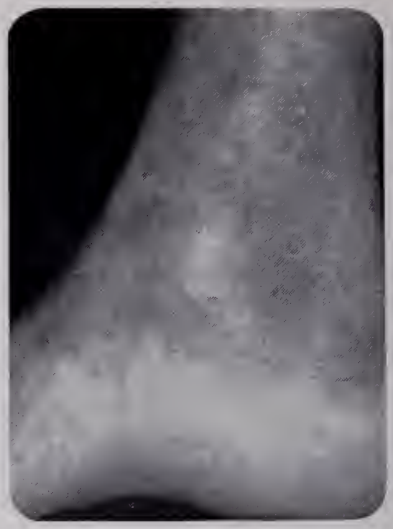
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VOLUME 64 AUGUST, 1966 No. 8

Mammography, Biopsy, and "The Lump"†

GEORGE B. SANDERS, M.D.
Louisville, Ky.

Mammography has proved helpful in certain instances, but is misleading in the evaluation of the palpable solitary or dominant lump, which is still the basic problem in breast cancer today.

IN THE situation of stalemate which characterizes the present status of breast cancer treatment, the use of mammography to detect occult breast cancer at a stage when the rate of metastasis is low, and curability presumably high, has captured the imagination of everyone with a special interest in the subject. Mammography has also been found to be a valuable aid in:

(1) The periodical examination of the surviving breast in mastectomized patients.

(2) The examination of large, fatty, or multinodular breasts.

(3) The evaluation of the homolateral and contralateral breast in the presence of a solitary or dominant lump, or in other situations, where biopsy is mandatory.

All these "fringe benefits" are eye-catching and intrinsically worthwhile, but they contribute little toward improving the management of the basic problem in breast cancer, namely, the treatment of the solitary or dominant lump in the breast.

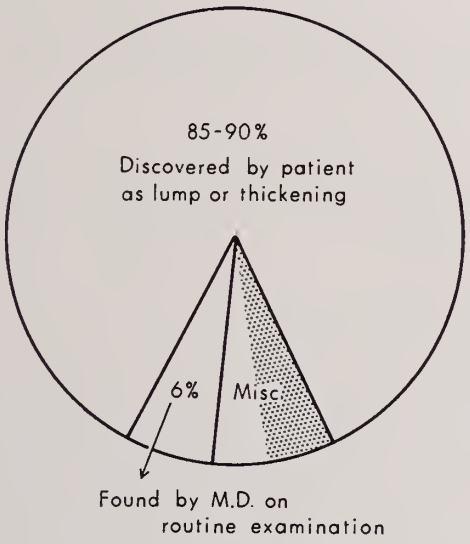


Table 1

At the present time, 85 to 90% of breast cancers are found by the patients themselves solitary or dominant lump or thickening.[9,10] (Table I) Continuing education of women in the significance of breast lumps, and education of their physicians in the proper management of such lumps by prompt biopsy, has produced statistically evident improvement in early diagnosis and treatment, even though the absolute mortality from breast cancer remains unchanged.[2,4,7,8,9]

†*Presented at the Norton Memorial Infirmary Eighth Annual Post Graduate Medical Seminar. December 16, 1965.*

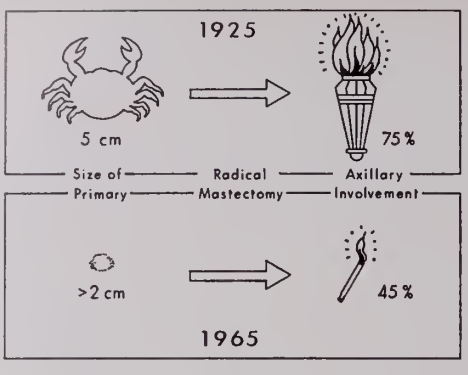


Table 2

This improvement can be summed up as follows: *Compared with forty years ago, today's breast cancers coming to treatment are generally smaller, with a lower rate of axillary spread, and with axillary nodes, if involved, confined largely to the lowest planes.*[2, 3, 7, 9] (Tables 2 and 3) There is reason to think that such cancers should be much more amenable to cure or control by mastectomy.[14,15]

TABLE 3*

Period of study	% With Auxillary Metastasis
1910 - 24	66.6%
1925 - 34	66.4
1935 - 44	57
1945 - 49	51.2
1950 - 54	47.6

* Berkson, J., Harrington, S. W., et al., Mayo Clinic.

Concurrent with these salutary changes has come a change other than size in the typical breast lesion under scrutiny today. Fewer present clinical stigmata of malignancy; more and more are in the category of the "nondescript" or "innocent" lump. (Table 2) In order to maintain the current high level of efficiency in diagnosis and treatment, the physician now finds himself forced to submit to biopsy many nondescript lumps which defy clinical diagnosis, but which may be cancer. Embarrassment over a negative biopsy is only partly balanced by relief, and patient and physician are eager for some method which will refine clinical diagnosis and reduce the number of fruitless biopsies.

In this sphere, alas, mammography has thus far failed to sharpen our diagnostic accuracy appreciably. Despite the optimistic statements of the mammographers, critical evaluation of mammography reveals no improvement in diagnostic accuracy in the case of the palpable lump, over the clinical diagnostic ability of a skilled physician with special training and interest in breast diseases.[1,14] The accuracy of good mammography is somewhat greater than the clinical accuracy of the average physician; but here also, the accuracy of average mammography done by a general radiologist, who is not trying for a record, collecting a series, or writing a paper on mammography, is considerably inferior to the kind of superb mammography which is compiling the statistics and getting the publicity.

It is important to remember that advances in breast cancer management thus far, have come about not so much from advances in diagnostic technology, and certainly not from technical improvements in curative treatment, *but from the increased readiness of patient and physician to submit apparently innocent small breast lumps to prompt surgical biopsy and appropriate therapy*. In the Minneapolis Cencer Detection Center, using physical methods of diagnosis alone, which have been available to the medical profession for a half century or more, early asymptomatic breast cancer has been diagnosed with an efficiency that has made possible in this clinic a dramatic increase in the over-all five-year survival rate from the former national average of 42% to an amazing 88%. In the group of breast cancer patients so detected and treated, axillary spread was found in only 24%.[7,13]

Regardless of the degree of accuracy of either clinical examination or mammography, diagnosis in breast cancer rests, as always, on histologic study of tissue obtained by biopsy, which should yield 100% accuracy. Methodology which encourages prompt biopsy will aid early diagnosis and effective treatment; that which discourages or delays biopsy will defeat this aim.

Delay in Diagnosis

The educational campaigns of the American Cancer Society and its regional divisions have done much to reduce delay, but much remains to be done. Forty years ago, the average interval between clinical diagnosis and treatment of breast cancer was in excess of twelve months. The most recent figures put it at about eight months. [9, 10]

The reasons for delay have been carefully studied and can be grouped under the following headings:

(1) Psychological—(Patient)
(2) Financial—(Patient)
(3) Iatrogenic—(Physician)

By and large, psychological factors such as fear of cancer, of hospitals, and of doctors, and fear of pain and operations; narcissism, lack of "tactilism" in the breasts, and other emotional aberrations comprise the largest group contributing to delay. However, 17% of a large group of women recently interviewed gave as the principal cause of delay, temporizing advice given them by their physicians.[9] (Table 4)

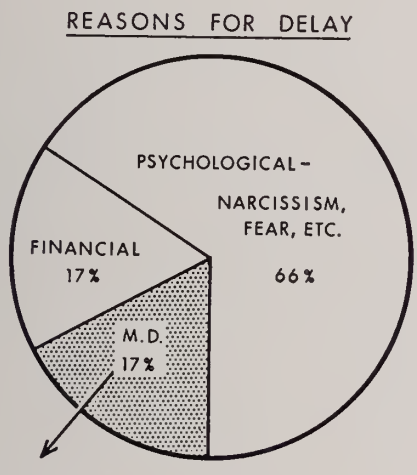


Table 4

These iatrogenic causes for delay have received special evaluation in several large centers.[10] Generally, they are as follows:

(1) Failing to examine a breast containing an obvious tumor while treating the patient for an unrelated disease.

(2) Failing to feel the tumor which the patient had discovered and for which she came to consult him.

(3) Disregarding history of acute and sharp pain in the breast.

(4) Mistaking a carcinomatous breast tumor for a breast infection and failing to advise biopsy.

(5) Wrongly diagnosing a carcinomatous breast tumor as a benign lesion and failing to advise excision or biopsy.

(6) Disregarding a definite retraction sign and failing to biopsy area beneath.

(7) Failing to determine the cause of a nipple discharge, by surgical exploration and biopsy.

(8) Relying upon an undependable method of diagnosis such as aspiration biopsy and mammography, and failing to employ surgical biopsy.

One can conceive of at least two mechanisms whereby mammography increases delay in bringing the cancerous breast lump to biopsy.

(1) The reluctant patient with a nondescript but cancerous lump obtains a negative or noncommittal mammography report. The negative report, which cannot be concealed from the patient, provides additional support for her refusal to submit to biopsy.

(2) The physician, whose patient has a nondescript lump about which he is hesitant and undecided regarding biopsy, orders a mammogram, hoping to tip the scales one way or another. The mammogram does not suggest cancer. Biopsy is postponed and the cancerous lump is "observed" further.

One or both of these mechanisms operating in conjunction with iatrogenic faults already cited, can reinforce the inherent error in logic which leads to greater delay in diagnosis and treatment. It has been reliably estimated that the additional delay caused by such maladroit or temporizing physician advice and management averages 12.5 months.[9]

Dangerous Wishful Thinking

It is natural to place subconsciously great reliance upon a mechanical technology employing a machine costing thousands of dollars, operated by highly trained technicians, and supervised and interpreted by a radiological specialist of intellectual probity and integrity. It is also easy and attractive to extrapolate subconsciously the impressive ability of mammography to detect occult nonpalpable cancer with an assumed ability to detect cancer in an early palpable nondescript lump in the breast. Unfortunately, facts do not support this fancied or hoped-for ability, and an error in the diagnosis of palpable cancerous lumps in the breast of 15 to 20%,[14,15] or even more under some circumstances, is the rule.

This type of wishful thinking is recognized as dangerous, and is exhorted against by Gershon-Cohen, Egan, and others, who have published large series of mammographic studies.[3,5,6,11,12,13,16,17]

All are unanimous that:

1. Mammography is not a substitute for biopsy.
2. Clinical indications for biopsy take precedence over mammographic findings.
3. Mammography is not yet accurate enough to determine between benign and malignant lumps that are palpable.

Nevertheless, in the wake of these clear warnings we have the following quotations taken from recent articles on mammography and breast cancer diagnosis.

"These radiologists have been quite successful in distinguishing between benign and malignant tumors by means of X-ray."

"Mammography has many attributes which go far toward achieving this goal (improvement of mortality statistics) . . . when a tumor is discovered . . . in a breast with a palpable mass clinically thought to be benign."

"Many occult carcinomas 1 cm. or 1.5 cm. in size have been recorded. Larger lesions are, of course, easier to diagnose . . . (by mammography)."

"This study (mammography) is not intended necessarily to reduce the number of breast biopsies but can do so in many instances when the examining physician's rather firm opinion of benign disease is supported by a firm mammographic diagnosis of benignancy."

"In fibrocystic disease, differentiation may be available from mammography, and a correct evaluation of a nodule obtained."

"When a decision against biopsy is made, the surgeon has at his disposal a pictorial record to which he has access for future reference and comparison."

"If instead of anticipating this sequence (biopsy) she could get assurance that there would be no operation until after X-ray studies were made, the respite and delay occasioned by the X-ray studies would give her time to collect herself with the hope that a benign process would be discovered . . . and this occurs in three out of four cases."

"Palpable malignant lesions rarely escape detection on the X-ray film."

"In the case of a finding that is clinically indeterminate as to malignancy a mammogram may tell him whether it is benign or malignant. It localizes the most suspicious of several possible lesions and thus defines the site where biopsy will be most useful."

"Before the introduction of mammography, if a physician was uncertain that a lump was not malignant, he could recommend biopsy. Now he has an alternative in mammography—a safe, simple, painless, and moderately inexpensive procedure. If women knew about this, they would be likely to agree to it, even if they had hesitated to agree to biopsy."

Each of these quotations constitutes a semantic inducement to substitute mammography for biopsy; an alternative with an average accuracy of 80% or less, in exchange for the 100% accuracy of surgical biopsy.

Articles on mammography deal in case series of many hundreds, or even thousands, where a diagnostic error of 15 to 25% does not loom large. Avoidance of comparison with surgical biopsy, and contrived comparison with the accuracy of physical examination of the breast, further heightens the false impression of mammographic dependability.

The physician (or surgeon) in community practice deals in individual cases where single errors are tragic. With this in mind, 16 consecutive cases of histologically proven breast cancer taken from the author's private practice were reviewed as to the mammographic accuracy of their preoperative work up. These were routine cases, none of which were obvious, advanced or disseminated carcinomas, most were diagnostic problems, all were palpable, none occult. The figures in the table speak for themselves.

CASE #	MAMMOGRAM	BIOPSY
1	+	+
2	−	+
3	+	+
4	+	+
5	+	+
6	−	+
7	−	+
8	+	+
9	−	+
10	−	+
11	+	+
12	−	+
13	−	+
14	−	+
15	+	+
16	+	+
Totals		
16	50% Accuracy	100%

Mammography is not a definitive diagnostic technic of great accuracy and should not be so used. It cannot be expected safely to arbitrate a situation where the decision to biopsy is not clear-cut. In such an instance, it is far safer, and in the light of the natural history of breast cancer, more logical, to do or urge a biopsy when such doubt exists. Like tracheostomy, the time to do it is when one first thinks about it.

It is worthwhile to repeat at this time the absolute indications for surgical biopsy of breast lesions, which should not be altered or emas-

culated regardless of mammographic findings. These are:

(1) To prove, by biopsy, the nature of every solitary or dominant lump or thickening in a breast.

(2) To biopsy every inflammatory mastitis or eczema of the nipple or areola, of over two weeks' duration.

(3) To biopsy the breast beneath every true retraction sign or dimple.

(4) To prove, by biopsy, the nature of every case of nipple discharge of recent origin.

Mammography may be employed to widen the scope of study of these problems, but does not alter the indication for biopsy.

"The price of skill in the diagnosis of breast carcinoma is a kind of eternal vigilance based upon an awareness that any indication of disease in the breast may be due to carcinoma. The physician's sympathy with a patient's distress, the seemingly benign physical character of a breast lesion, a natural desire to avoid all the hard work that goes into dealing with a carcinoma—all conspire to lull the physician into a state of mind in which he tends to think of the lesion as benign. The only way to avoid this kind of error is to follow the strict rule of always explaining to the patient that the clinical evidence is not final, and that the definitive diagnosis is based upon the microscopical findings after biopsy. She must always be told of the possible necessity of radical mastectomy, and must give her approval. All of these preparations, if they serve no other purpose, keep the surgeon alert to the threat of carcinoma."[10]

Summary

(1) Diagnosis in breast cancer is made by histologic study of tissue obtained by surgical biopsy. If biopsy is omitted, regardless of all other diagnostic aids and studies, the diagnosis is in doubt.

(2) One such diagnostic study, an X-ray technic of great promise called mammography, used in its proper place, has proved helpful in the management of some aspects of the breast cancer problem; namely:

a. Detection of occult, impalpable carcinoma.
b. Evaluation of homolateral and contralateral breasts where biopsy of one breast is indicated.
c. Periodic evaluation of surviving breast after radical mastectomy.
d. Evaluation of large, fatty, or multinodular breasts.

(3) Mammography as yet lacks the accuracy to be helpful in evaluating palpable solitary or dominant lumps in the breast. Because of this, it cannot be used to arbitrate a difficult decision on whether or not to biopsy a nondescript, innocuous-appearing, lump in the breast, and should not be so used.

(4) Although it has been hoped that mammography will shorten the delay that intervenes between the discovery of a cancerous lump and its proper management, it may often, because of its psyhcologic effect on both doctor and patient, increase such delay, in the event of a false negative, or noncommittal report, by impeding and delaying the decision to biopsy.

(5) Despite mammography, the fundamental tenets of successful cancer management, which, in the past, have made biopsy mandatory in every solitary or dominant lump or thickening in the breast, every persistent mastitis or nipple eczema, and every recent nipple discharge should remain unaltered, and, indeed, should be re-emphasized with greater intensity.

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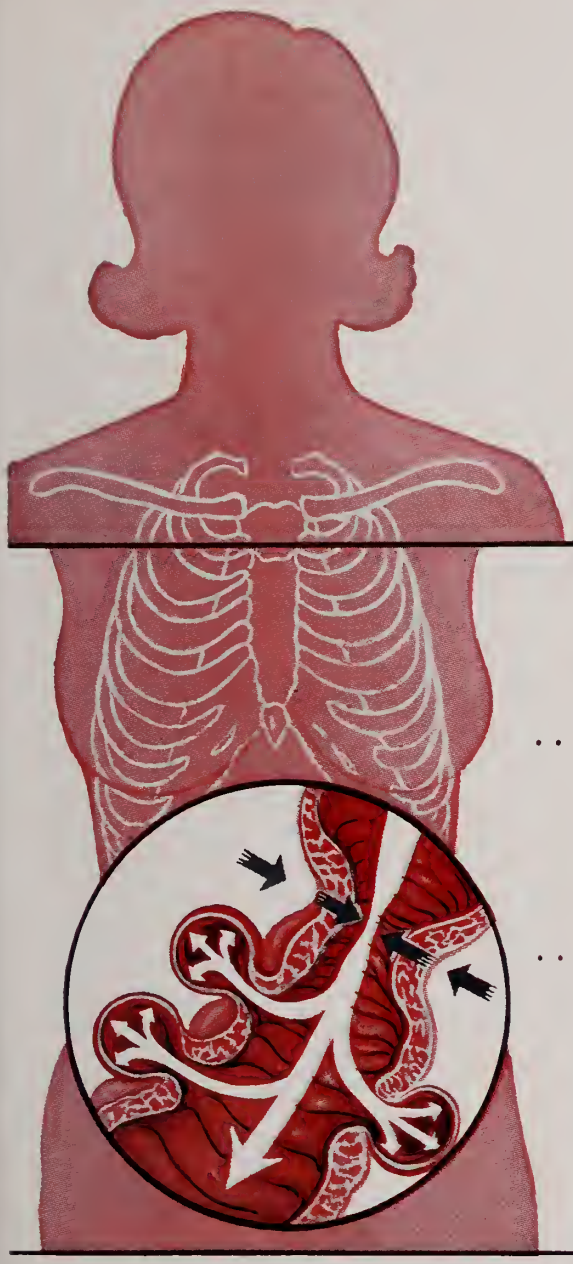
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Research in the Service of Medicine

Genetics in Medicine

E. David Weinstein, M.D.*

Lexington, Ky.

The past several years have seen tremendous growth in genetics in medicine. Modern medical practice will be making use of medical genetics when dealing with inherited diseases. The University of Kentucky is developing programs to meet this expanding need.

ALMOST exactly 100 years have elapsed between Gregor Johann Mendel's original dissertation on the study of hereditary transmission[1] and the awarding of the Nobel Prize to Jacob, Monod and Lwoff in October of 1965, for their remarkable work on regulator genes.[2] The first 35 years of the century since Mendel's paper saw no progress at all, for his work remained unrecognized until 1901 when the theory of hereditary transmission put forward by Mendel was rediscovered almost simultaneously by three European botanists.

The study of genetics grew steadily after 1901, mostly in the areas of plants and animal studies. It then fell into ill repute in the 1930's when eugenicists used it for purposes of racism culminating, of course, with the Nazis in World War II.

In the past 10 to 15 years there has been a remarkable expansion of knowledge in all fields of medical genetics.[3] For purposes of discussion, medical genetics can be divided into six fields: Molecular genetics, Cytogenetics, Pharmacogenetics, Inborn errors of metabolism, Population genetics, and Genetic counselling and preventive medicine.

Molecular Genetics

Some examples of the tremendous strides that have been made in molecular genetics are: the demonstration of the structure of deoxyribose nucleic acid (DNA), the genetically active component of the chromosome; the beginning of the unraveling of the genetic code by showing that small discrete segments of the DNA molecule (genes) act as code words for specific amino acids; the finding that the genetic "message" on the DNA molecule is translated through an intermediary, ribose nucleic acid (RNA) into specific chains of amino acids (polypeptides or proteins) having to do with specific structure (collagen, muscle), function (hemoglobin, hormones) or metabolism (enzymes); and the lucid evidence that point alternations in the DNA molecule (mutation), lead to point alterations in a protein molecule (amino acid substitution) which may lead to a completely altered functional state such as a hemoglobinopathy.

The entire pathologic state involved in sickle cell disease is the result of the substitution of one specific amino acid (in one of the four protein chains that comprise hemoglobin) which in turn results from a single point mutation at one of the hemoglobin loci of the DNA molecule involved. However, it is still speculative why such an amino acid substitution should produce the drastic change in solubility of the whole hemoglobin molecule to which has been ascribed the origin of the sickle cell anemia itself.

Cytogenetics

In 1956 Tjio and Levan demonstrated that the normal human diploid chromosome number is 46.[4] Lejeune, Gautier and Turpin,[5] three French investigators, demonstrated the first human chromosomal abnormality in 1959. They discovered an extra small chromosome (total 47) in tissue cultures established from several mongoloid imbeciles. Also in 1959, Ford and coworkers[6] described the second human chromosomal abnormality, absence of one of the sex chromosomes (total 45) in Turner's syndrome.

Human cytogenetics is not only of great practical value in helping to define the etiology of malformation syndromes and abnormalities

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of sexual differentiation but it also has value in preventive medicine. Examples of the latter would be the detection of translocation chromosomes in young mothers with a high risk of recurrent mongolism[7] as well as detection of parental chromosome mosaicism that could lead to repeated offspring with chromosomal abnormalities.[8]

Pharmacogenetics

Pharmacogenetics is the study of gene controlled differences in drug actions. A recent well worked out problem in pharmacogenetics is the one in which hemolysis is induced by the 8-amino quinoline anti-malarial drugs (primaquine, pamaquine).[9] This sensitivity to antimalarials as well as sulfonamides, nitrofurans, aspirin, and naphthalene mothballs is due to a sex-linked red blood cell deficiency of the enzyme glucose-6-phosphate dehydrogenase (G-6-PD). This trait is found in about 10% of American Negroes. A similar, genetically determined G-6-PD deficiency is responsible for the hemolytic disease "Favism" seen in peoples of the Mediterranean when they are exposed to the fava bean.

Many drugs in common clinical use may precipitate hemolysis. The danger of iatrogenically induced acute anemia with a familial basis has to be weighed by physicians in their selection of therapeutic agents.

Inborn Errors of Metabolism

Phenylketonuria (phenylpyruvic oligophrenia or PKU), one of the inborn errors of metabolism, is a disease known by all physicians especially those who deal with pediatrics. Other such diseases include histidinemia, maple syrup urine disease and Hartnur disease.[10] Medical genetics and biochemistry have elucidated the etiology of PKU which is known to account for about one (1) percent of the patients in institutions, schools, and homes for the mentally retarded.

PKU is known to be an inborn error of amino acid metabolism resulting from the homozygous state of an autosomal recessive gene. Deficiency of the enzyme phenylalanine hydroxylase renders it impossible for these patients to metabolize properly the amino acid phenylalanine with the subsequent build up of secondary metabolic products (phenylacetic and phenylpyruvic acid) which are thought to be the agents that lead to brain damage in these children.[10] A low phenylalanine diet instituted soon after birth in these children is making a significant difference in the outcome of their lives as well as decreasing the total burden of severe mental deficiency.

Population Genetics

Population genetics deals with the characterization of populations by their gene content (gene frequencies), as well as studies of fertility, consanguinity (cousin marriages) and linkage between various genes. With the addition of modern serum antibody studies as well as multiple red blood cell and plasma factors the study of disease pressures and subtle genetic pressures has been added to the work of the population geneticist.

One practical point of information learned from population genetics is the enormity of the problem of the genetic carrier. The relative frequencies of homozygous normals, heterozygous carriers, and homozygous affecteds concerning an autosomal recessive gene such as PKU, Wilson's disease or cystic fibrosis are expressed respectively by the Hardy-Weinberg formula, $p^2 + 2pq + q^2$. Recent estimates of the frequency of PKU in the general population is about 1 in 10,000.[3] Therefore, $q^2 = 1/10{,}000$ or 0.0001 and the gene frequency of PKU $(q) = 0.01$. The frequency of the normal allele $(p) = 1 - q$ or 0.99. The heterozygote carrier frequency $(2\ pq) = 0.0198$ or 198 carriers per 1 affected or per 10,000 population. Therefore about 1 person in 50 will be a heterozygous carrier for the gene for PKU, showing the importance of the carrier state in preventive medicine. As yet there is no thoroughly effective way to demonstrate the carrier state other than by two parents giving birth to an affected child (progeny test). It is felt to be only a matter of time before effective tests are available for the positive identification of many of these carrier states.

Genetic Counselling and Preventive Medicine

Some of the problems of genetic counselling and preventive medicine have already been touched on concerning the inheritance, chemistry and population aspects of PKU. In addition to diseases with a clear cut genetic (PKU) or chromosomal (mongolism) etiology other

more complex problems come to the person interested in clinical genetics. These include congenital malformations (cleft lip and palate, spina bifida cystica), familial diseases (epilepsy, diabetes), consanguinous marriages as well as problems of a social nature such as disputed racial ancestry or disputed paternity.

Proper genetic counselling with the aid of certain laboratory procedures has become a strong tool in preventive medicine through dissemination of pertinent risk information.

Medical Genetics at the University of Kentucky Medical Center

At present there are four specific services available in Medical Genetics. The Birth Defect Clinic has been established for the purpose of diagnosis, treatment and follow-up of all types of birth defects with special emphasis on metabolic problems. The cytogenetics laboratory has been established for the purpose of chromosome analysis for those cases in which such a test may be of help in delineating the diagnosis or aiding in the prognosis for recurrence of certain diseases. The hemoglobin laboratory can be used to help define hematologic problems that may be related to hemoglobinopathies or thalassemia. The fourth service available is the Heredity Clinic where genetic counselling may be obtained on any genetic, familial or congenital malformation problem.

A few selected family studies that have been conducted since July of 1965 may serve to illustrate the clinical, laboratory, and public health aspects of Medical Genetics at the University of Kentucky Medical Center. Chromosome analysis performed on the Ma. family was of significant value not only to the family but to the community as well. A mongoloid child had been born to Mr. and Mrs. Ma. when they were 18 and 17 years old, respectively. The chromosomal studies showed the mongoloid child to have the regular trisomy, 21, and the parents as well as a normal younger sibling to have normal chromosomes. This gives the family a risk of about one chance in 500 of recurrence of mongolism as compared to about one chance in three if either parent had been carrying an abnormal translocation chromosome.

The Me. family was studied because a sickle cell preparation was positive in the father. Hemoglobin electrophoresis showed the father to be heterozygous for the sickle gene (carrier of the trait), while the mother and five children had normal hemoglobin. These results indicated there can be no cases of the severe sickle cell anemia in this fanily nor in the next generation born to the five children.

Mrs. Sm. was referred to the Heredity Clinic because three of her six children had died of cystinosis before the age of eight years. Mrs. Sm. was concerned about the disease recurring in the future offspring of her three normal teenage daughters. Because cystinosis is inherited as an autosomal recessive it was explained to the mother that there was only a small risk, (1 in 600) that any of the three daughters could have a child with cystinosis. This was far below what the family had surmised the risks to be.

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Progress in Otolaryngology

Robert C. Kratz, M.D.*
Newport, Ky.

This has been a fruitful decade for progress in the Ear, Nose and Throat specialty. Advances have been made in the treatment of sinusitis, deafness, Bell's palsy, parotid gland tumors, Menierie's disease, and plastic procedures.

CHRONIC sinusitis is considered by most otolaryngologists to be related to allergy complicated by infection. At times endocrine and anatomical factors are also involved. Most otolaryngologists use the minimum optical dosage therapy developed by Hansel[1] and Rinkel[2] in the treatment of sinusitis. Specifically allergenic foods and inhalants, of which house dust is the most important, are controlled. Nutrition is improved. Antibiotics, antihistamines and sinus irrigations are often used. Surgery is rarely necessary.

Nose drops have fallen into disfavor among many ENT specialists. This trend began with the work of Proetz[3] on nasal physiology. He states that vasoconstrictors are harmful and that most topical medications disturb the mucous covering which protects the delicate pseudostratified ciliated epithelium of the nasal membrances. Recently Premarin 20 mg. in distilled water has been advocated in the treatment of ozena and atrophic rhinitis by Zeman,[4] and it has been found effective in my own practice.

Bell's palsy which it seems is due to a disturbance of the blood supply of the facial nerve has recently become a more predictable disease. The nerve excitability test described by Campbell[5] enables the physician to decide if decompression of the nerve in the facial canal is indicated. An electrical pulse of 1 millisecond duration is repeated once per second. The nerve which responds fully at the same current intensity as the normal (usually 3 milliamps) has a physiologic block and will recover. The nerve which responds but requires more current than the normal has partial degeneration. The nerve which fails to respond in spite of high current intensity has complete degeneration and surgical decompression is indicated. Medical treatment is nicotinic acid, 100 mg. every three hours. Some are using cortisone and of course if ear infection is present, large doses of penicillin or the indicated antibiotic should be used.

Parotid gland lesions were once treated conservatively and often ineffectively because the physician feared the dread facial paralysis which so frequently followed surgery of this difficult area. Kratz[6] and many others expose the facial nerve at its emergence from the skull and with the nerve in view, remove part or all of the gland without injury to the nerve. Chronic suppurations, tuberculosis, foreign bodies and tumors are now handled surgically in an effective manner.

Otology has perhaps progressed more than any other surgical specialty. The operating microscope has brought this discipline from the hammer and gouge era to the present era of the microdrill and the micropick.

Deafness due to serous otitis media is controlled with allergic management, antibiotics, and small Teflon tubes placed permanently or semi-permanently through the eardrum. These equalize the pressure on each side of the drum.

The perforated eardrum is routinely repaired with grafts of fascia and vein often covered with ear canal skin. When otitis media has destroyed the continuity of the ossicular chain causing a conductive deafness, various repositioning operations and prosthetic substitutions are used. Cholesteatomas are removed and the ossicular chain is repaired or a prosthesis is substituted.

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Conductive deafness due to otosclerosis of the foot plate is usually controlled with a stapedectomy and substitution of a prosthesis.

Nerve deafness may some day be largely prevented through the control of Meniere's disease, control of noise in industry and a better understanding of the metabolism and nutrition of the cochlea.

Meniere's disease has been described by Goldman[7,8] as a hypometabolic state related to hormonal dysfunction. It is a part of the stress syndrome and is a localized manifestation of hypoadrenalcorticism. A regime of treatment effective in my office has been Bellergal Space Tabs, morning and night, Lipoflavonoid, 2 capsules three times daily, whole adrenal cortical hormone, thyroid, estrogen or testosterone when indicated. A low carbohydrate diet is 50% of the treatment.

Progress in reconstructive and plastic surgery of the head and neck has been phenomenal. We are able to correct lop ears with one day's hospitalization and to put calf cartilage which comes pre-prepared into defects of the nose and face. Full thickness skin grafting techniques seldom fail when used about the nose. Modern photographic techniques such as 1 to 1 life size photography of cleft lips and scars, make it possible to plan the procedure systematically before entering the operating room.

Progress in the management of head and neck cancer has been encouraging. Cobalt is being used in preference to X-ray, preoperatively and postoperatively in some cases.

Summary

This has been a fruitful decade for progress in the Ear, Nose, and Throat specialty.

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In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater leadership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

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The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

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AMA Delegates Act on 58 Reports and 106 Resolutions At Lengthy Annual Session in Chicago, June 26-30

Because of the unusual importance to KMA Members, the full report of the action of the 1966 annual meeting of the AMA House of Delegates in Chicago, prepared by the Executive Vice-President, F. J. L. Blassingame, M.D., is published here for your information.
The Editors

FEDERAL health legislation, physicians' billing procedures, medical ethics, racial discrimination, health manpower and an increase in AMA annual dues were among the major subjects acted upon by the House of Delegates at the American Medical Association's 115th Annual Convention held June 26-30 in Chicago.

Milford O. Rouse, M.D., of Dallas, Texas, Speaker of the House of Delegates for the past three years, was named AMA president-elect by acclamation. He will succeed Charles L. Hudson, M.D., of Cleveland, Ohio, who took office at the Tuesday afternoon inaugural ceremony during the Chicago convention.

Final registration reached a total of 35,506, made up of 12,445 physicians and 23,061 guests.

Federal Health Legislation

The House of Delegates received and considered a large number of reports and resolutions dealing with Medicare, the expanded Kerr-Mills program under Title 19 of Public Law 89-97, and other federal laws or programs.

In accepting and commending a Board of Trustees report on Medicare, the House recommended that "the Association give wide dissemination to the information contained therein, particularly its informed discussion of direct billing, the basic purposes of utilization review, the rejection of compensation for service on such committees except in exceptional circumstances, and the proper placement of any onus of responsibility for any failure in the Medicare program."

The Board report ended with the following conclusion:

"During the past year many individuals have represented the American Medical Association and the physicians of the United States by meeting frequently with officials of the Department of Health, Education and Welfare. This degree of cooperation on our part should be viewed as a recognition by responsible citizens of an obligation to obey the law of the land, including this law with which we disagree.

"Our specific purposes have been to provide expert assistance to the government so that this law could be implemented in a manner most helpful to the beneficiaries while disturbing the practice of medicine to the minimum degree. Despite our best efforts it is apparent that serious problems are inevitable in connection with the implementation of this law and we trust that the physicians and the public will place the blame for such deficiencies squarely where they belong—on the Federal Government.

"We are proud of the role we have assumed and in many instances our efforts have been productive. Proposed forms were simplified; some unnecessary forms eliminated, and a number of our suggestions was incorporated in regulations and procedures. An informative "Reference Guide" for physicians, recently distributed, was prepared with consultation of AMA staff.

"Numerous other items will continue to receive our most serious study and consideration, and the Board urges and requests that every member exhibit his personal diligence by supplying his local medical society documented evidence of transgressions of the spirit or the letter of the law as it is implemented.

"The Board of Trustees intends to continue to supply advice, guidance, and dissent when necessary to the Government or to other third parties on matters that pertain to the health of the public and the interests of the medical profession."

The House strongly supported the general concept of individual responsibility and endorsed a report from the Council on Medical Service which included the following statement:

"Since the Council believes that the current interest in the doctrine of individual responsibility stems in large part from concern over the matter of assignments under PL 89-97, it hastens to add that, as a matter of American Medical Association policy, the Council on Medical Service recommends reaffirmation of the responsibility of individual physicians for determining how they will govern their professional practices under this law and that physicians should be made acutely aware of the manifest superiorities of direct billing as previously communicated to this House in the Council's Report E (A-66) on Recommendations on the Physician's Role in Medicare.'"

The latter report (Report E) was highly commended, and the House recommended its widest possible dissemination, including publication in its entirety in a prominent place in the earliest possible issue of *AMA News*.

Physicians' Billing Procedures

In connection with the Medicare part of Public Law 89-97, the House also adopted three resolutions which recommended that physicians use the direct billing method rather than the assignment procedure. At the same time, the House pointed out that adoption of these resolutions should not be interpreted as contravening the statement approved at the Special Session in October, 1965, which said:

"The American Medical Association opposes any program of dictation, interference or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97."

In considering a resolution on the right to bill patients under Title 19 of the law, the House passed an amendment pointing out that direct billing has been recommended as the billing method of choice under Title 18 by the Board of Trustees and the Council on Medical Service. It then said that since there is a wide latitude available to the states in establishing administrative procedures under Title 19, each state medical association should work early and diligently in its own state so that any plan or law adopted in its state for approval under Title 19 would include authorization for direct billing.

The House also instructed the AMA Advisory Committee to the Department of Health, Education and Welfare to do all in its power to implement the intent of the resolution at the national level. In addition, the House urged positive steps to obtain statutory authority for a continuing medical advisory committee under Title 19, and it called on the AMA and the state societies to maintain added vigilance to eliminate any patterns which might subvert the intent of Title 19.

Hospital-Based Physicians

The House passed two resolutions involving billing and reimbursement principles affecting hospital-based specialists but also of significance to all physicians. The first said:

"The Principles of Medical Ethics declare that a physician shall not dispose of his services to a third party or "lay" organization, and

"Title XVIII of Public Law 89-97 recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians; and

"This principle has been advocated by the AMA, the American College of Radiology, the American College of Pathologists, and many regional organizations, and

"A great number of hospital-based physicians throughout the nation have declared their intention to bill separately for their professional services in keeping with this principle; therefore be it

"Resolved, That, since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing."

The second resolution regretted that publication of Medicare Regulations #5 was delayed until June 28, three days before the effective date of Medicare, and said that these regulations do not conform to the intent of Congress as expressed in Section 1801 of the Medicare law. It then declared that:

"The House of Delegates instruct the Board of Trustees and the Executive Vice President to request from the Social Security Administration an extension of date of final adoption of the proposed regulations of not less than 90 days, in order that the American Medical Association and all other interested medical organizations be allowed reasonable time to study, and to submit, to the Social Security Administration data, views or arguments and pertinent constructive comments and suggestions.

"To preserve the professional independence of medical practice that the Board of Trustees and Officers of the AMA be instructed to immediately inform the membership that Medicare Reg. #5 will not apply to physicians (whether hospital-based or not) who

"1. have no financial relationship with a hospital covering medical services to patients

"2. do not accept assignments but bill directly

"*The AMA News* and other appropriate media be used to advise all physicians who are developing contractual relationships with hospitals for professional service that they should delay the finalization of any agreements pending further anaylsis of the implementing regulations."

Medical Ethics

In acting upon a Board of Trustees recommendation that a physician may participate in the ownership of a pharmacy or regularly dispense drugs, remedies or appliances or provide eyeglasses to his patients only when approved by his component and constituent medical associations and when it is determined by them to be necessary in the best interests of the patient, the House approved the following reference committee statement:

"The Principles of Medical Ethics provide: 'Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.' Your reference committee reaffirms the 1963 House of Delegates interpretation of the words 'in the best interest of the patient,' which reads as follows:

" 'It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when car-

ing for his patient. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done.

On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense "in the best interest of his patient"; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.'

"The reference committee approves the goals sought by the Board's report, but disapproves its specific recommendations. It notes that mechanisms presently exist for processing charges of deviation from the foregoing ethic and urges that these mechanisms be made vitally active at local level. When charges of deviation develop, complaints should be made to the local society and vigorously processed by the appropriate committee of that society. If they are not resolved thereby, the complaints should then be carried to the state constituent association. The prudent physician will always seek the guidance of his local medical society in situations relating to ethical conduct."

The House directed the Board of Trustees to take action as expeditiously as possible to give wide dissemination to the reference committee report.

Discrimination

The House received six resolutions dealing with the subject of discrimination against some applicants for membership in component medical societies. It called attention to the strong position taken by the House in 1964 but pointed out that it is difficult to follow the 1964 directive because there is now no mechanism at the national level whereby a rejected applicant for membership at county or state level may obtain a hearing in order to right an alleged wrongful discrimination.

In lieu of the six resolutions, the House adopted a substitute resolution which directed the Council on Constitution and Bylaws to prepare such changes in the constitution and bylaws "as may be necessary to permit the Judicial Council to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in a local and/or state society." The House asked the Council to report its recommendations at the 1966 Clinical Convention.

Health Manpower

On the subject of health manpower the House received reports from the Board of Trustees, Council on Medical Education and Council on Medical Service and also one resolution. In general, all of them urged the AMA to assume leadership and mobilize its efforts to meet present and future shortages in health manpower. The House approved the Board report announcing appointment of a Committee on Health Manpower, and adopted the resolution. The two Council reports were referred to the new Board committee.

In taking these actions, the House approved a reference committee statement which included the following:

"Your Reference Committee is well aware of the drastic shortage of health manpower that is confronting the American public. It is keenly appreciative of the opportunity presented to the American Medical Association to furnish leadership in the solution of this problem. The necessary additional manpower in the medical profession and in allied health professions must be developed. The most effective and efficient utilization of existing health manpower must be made at all times. This is no time to surrender leadership to persons or organizations outside of the medical profession."

AMA Dues Increase

By a vote of 168 to 46, the House approved an increase in AMA annual dues from $45 to $70, effective January 1, 1967, thus confirming a Board of Trustees recommendation which was given initial approval at the 1965 Clinical Convention.

The House, in approving the dues increase, accepted a reference committee statement which said:

"It is quite apparent that the programs necessary to serve the needs of the members of the Association cannot be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the Board of Trustees. Your Reference Committee reaffirms its confidence in the judgment of the Board of Trustees which has in the past and must in the future exercise the most careful and prudent stewardship over the assets of the Association. The Board of Trustees is the Committee elected by the House of Delegates to investigate and control the finances of the Association. The appointment of any other committee to perform this function would be most inappropriate.

Other Actions

In considering 106 resolutions, 38 Board reports and at least 20 additional reports from councils and other groups, the House of Delegates also:

Endorsed the Declaration of Helsinki, already adopted by the World Medical Association, as a guide to those who are engaged in clinical medical investigation;

Reaffirmed its opposition to the compulsory assessment of hospital staff members in order to raise funds for hospital construction;

Reconsidered its action in defining usual, customary and reasonable fees and referred the matter back to the Council on Medical Service for further study;

Urged all state and county medical societies to send representatives to the Third National Congress on Medical Quackery to be held October 7-8, 1966, in Chicago;

Commended the American Medical Association Education and Research Foundation for its accom-

plishments during the past four years and gave a standing vote of gratitude to Dr. Raymond M. McKeown, AMA-ERF president since 1962;

Strongly endorsed the AMA Volunteer Physicians for Vietnam program and urged the entire profession to support it by word and deed; approved a recommendation by the AMA survey team and the Board of Trustees that the Association organize and administer a program of American assistance in medical education in South Vietnam supported by the U.S. Agency for International Development; was impressed by a report from Dean Pham Bieu Tam of the Faculty of Medicine, University of Saigon, and urged that the AMA do everything possible to assure that volunteer physicians caring for the South Vietnam civilian population are properly supplied with medicines and other medical supplies;

Adopted a resolution urging constituent medical associations to oppose, as detrimental to the public interest, any proposed legislation that would authorize optometrists to engage in the diagnosis or treatment of disease or injury of the eye;

Approved, with minor editorial revisions, a final report from the Committee on Maternal and Child Care of the Council on Medical Service dealing with the medical care aspects of "Combating the Problems of Unwed Parents";

Agreed with a strong policy statement condemning the abuse of LSD and other non-narcotic drugs, pointing out that the illicit use of LSD is subverting and vitiating important and necessary valid experimental studies, and recommending that the manufacture and distribution of LSD be continued as needed under strict control, with the drug being made available only to competent research workers (physicians trained in its use) on approval of the Department of Health, Education and Welfare;

Reaffirmed its opposition to the compulsory regulation of any single method, such as the use of generic terms, of the prescribing of drugs;

Offered AMA cooperation, in order to prevent public fear and misunderstanding, to those foundations and other groups which request it in clarifying statistical data, visual media and other forms of medical information to be presented to the public so as to provide an accurate view of the problems or problem with which they are concerned;

Adopted a humorous resolution and an equally humerous reference committee report which requested that "in the future full air-conditioning for the annual AMA Convention in those cities where the psychophysiological effects of heat may interfere with effective delegatemanship";

Received as information a comprehensive report, Relation of Medicine and Osteopathy, which contains much material pertinent to future policy considerations, and also approved in principle a recommendation that doctors of osteopathy be commissioned in the Armed Forces Medical Services;

Agreed with a report recommending that the core curriculum plan for continuing medical education be not approved in its present form, that no further core curricula be developed at this time, and that various methods of continuing medical education be studied under the auspices of the Council on Postgraduate Programs;

Expressed its opposition to the Hart bill, S. 2568, and all similar legislation;

Adopted reports from the Council on Medical Service on a Model Emergency Department Agreement and on Multiple Coverage in Voluntary Health Insurance;

Approved Board reports on Exercise and Physical Fitness, encouraging state and local medical societies to support the promotion of fitness programs, and on Venereal Disease Control, emphasizing the continued need for all physicians to report all cases that come to their attention, and

Authorized the Speaker of the House to appoint a Resolutions Consultation Committee, purely for editorial advisory purposes, at subsequent AMA conventions.

Presidential Addresses

Calling upon the medical profession for strength and unity in resisting the present socialist trend in this country, James Z. Appel, M.D. of Lancaster, Pa., retiring AMA president, told the Sunday opening session that physicians "must participate in the ranks of both political parties and have a voice in the determination of party policy and the writing of party platforms."

Dr. Hudson, in his inaugural address Tuesday, declared that "we shall need all of our intellectual and scientific resources to cope with the new economics of medicine" and to prevent the extension of the Medicare program, without demonstrated need, toward a national health service.

Speaking at the final session of the House on Thursday, Dr. Hudson said that "a demonstration of our ability to perform must clearly indicate not only our competency in the field of medicine, but also our ability to react to a new kind of government thrust into health care." He warned that the real threat to our system of medicine is not in the details of Medicare implementation but in the expansion of the principle of social insurance.

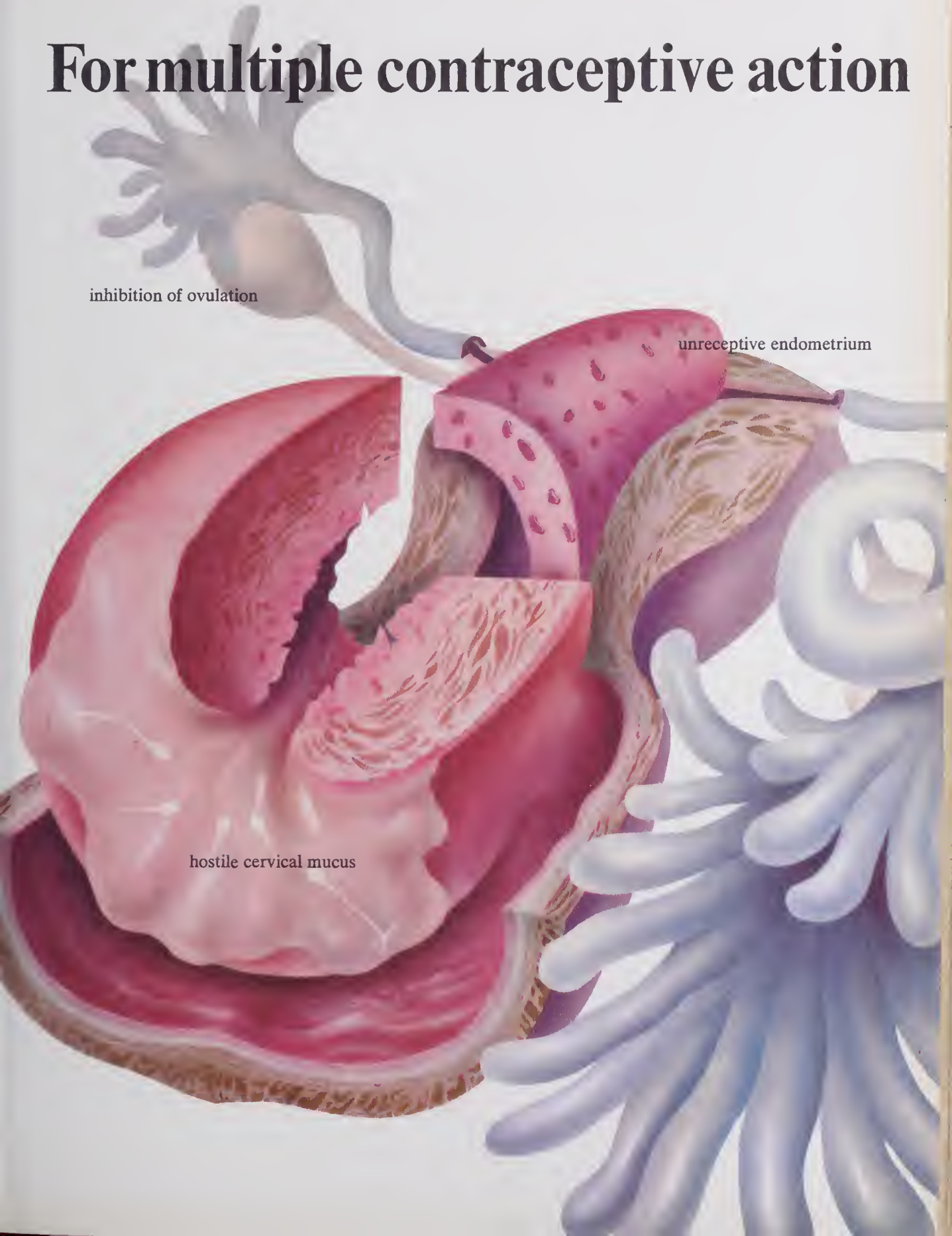
Election of Officers

In addition to Dr. Rouse, the new president-elect, the following officers were named:

Eli S. Jones, M.D. of Hammond, Ind., AMA vice president; Walter C. Bornemeier, M.D. of Chicago, speaker of the House of Delegates, and Russell B. Roth, M.D. of Erie, Pa., vice speaker.

On the Board of Trustees, all for three-year terms, Homer L. Pearson, M.D. of Miami, Fla., and Dwight L. Wilbur, M.D., of San Francisco were re-elected; Burtis E. Montgomery, M.D. of Harrisburg, Ill., was named to succeed Percy E. Hopkins, M.D. of Chicago, who did not run for re-election, and Max H. Parrott, M.D. of Portland, Oregon, succeeded Raymond M. McKeown, M.D. who was eligible for re-election.

For multiple contraceptive action



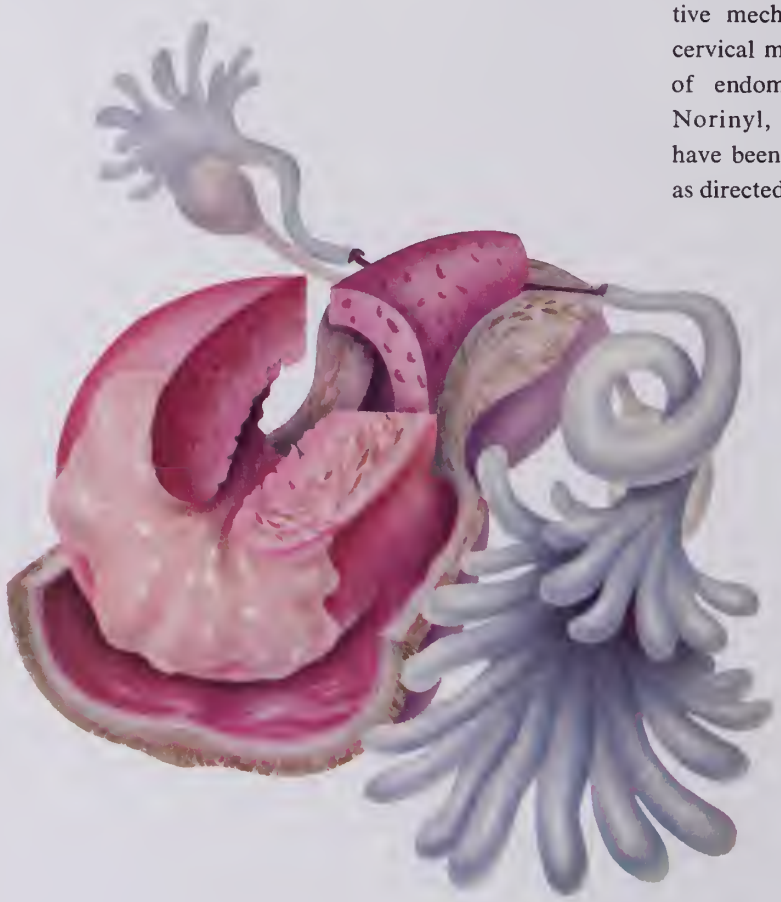
Norinyl® tablets
(norethindrone 2 mg. c mestranol 0.1 mg.)

multiple action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation



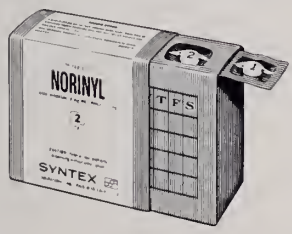
no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects
Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage
An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:4D2 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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EDITORIALS

Unwarranted Implication

DURING the past few months an enormous volume of writing has been done on the general subject of Medicare. There has been much speculation on what difference this innovation would make to the health care of the people, and to the cooperation and attitude of individual practicing physicians. Running through the mass of material has been a thread of suggestion or implication that the adoption of government sponsored medical care for older people would signal a rise in physicians' fees for this group. A brief article taken from the Courier-Journal of July 3, 1966 and accredited to Mr. David R. Jones of the New York Times News Service airs this subject briefly. He states: "Some government authorities, including experts within the Social Security Administration that is administering Medicare, suspect the new program is prompting more fee increases than the doctors will admit. But they are remaining silent because they concede there is no solid evidence."

A candid survey of fees charged by physicians and surgeons for the usual items of medical and surgical service was collected last year by our Physicians Mutual Incorporated. The data was tabulated and served as a basis for renumeration. The vast majority of the charges submitted were within the range normally accepted as fair and reasonable. Where they exceeded or fell short of the normal range the physician had an opportunity to alter the figure before it became a part of the general information. It was reported to us by Physicians Mutual at the end of a year of operation that the program had proceeded much better than had been anticipated and that at least 98.5% of claims submitted by physicians had been accepted and paid without question or investigation.

From this experience and from such information as has been gathered elsewhere by Blue Cross-Blue Shield, Independent Insurance Carriers, and the American Medical Association it would seem very improbable that any widespread or gross abuse of fees should be expected under the new system of medical care for the aged. We will undoubtedly be better informed on that point a year from now than today.

SAM A. OVERSTREET, M.D.

Doctor Kildare, Meet the Fossils

THE liberals with the easy answers to the problems of medical care, having politically sentenced the profession to successfully operate a Medicare we have said is unwieldly, are not resting on their laurels. A review of publisher's lists and of the mass circulation magazines show a normal crop of books and articles exposing and unmasking the medical profession, hospitals and various facets of medical care.

There is a dreary similarity in so many of these. Physicians off elsewhere are mercenary, knife-happy, negligent or (more recently), fiendish experimenters. For reader credibility, our local Doctor Kildare, be he a specialist or generalist, is recognized as struggling manfully to be a paragon of scientific attainment and the soul of integrity, despite his patient load and the information explosion. The writers imply that all would be well if kindly Doctor Kildare were not misled into unsocial attitudes by the fossilized leadership of his medical organization.

"Fossilized" seems to have an irresistible fascination for these liberals in describing the AMA. Because of their lesser guilt, I would hope that the critics would leave the Kentucky medical leadership some dignity as "semi-fossilized", rather than the more frivolous "Fossils, jg".

Unfortunately, this charge of fossilized leadership has been printed so many times that some physicians believe it. As the Speaker of the House of Delegates, I am inviting all physicians of Kentucky to watch and guide leadership in action, at the Sessions of the KMA House on September and important decisions will be made that will effect every practice and every professional career. It is not only your privilege, but in your enlightened self-interest, to contribute to the thought and debate that leads to correct decisions.

In the formal transactions that are necessary if the House is to discharge the many routine but necessary actions of a large and diverse organization, only Delegates are permitted to speak during sessions. Your thoughts should be given to your Delegate at the Pre-convention meeting of the County Medical Society. In addition, you will be welcome to present any further thoughts at the meetings of the Reference Committees, which will be held specifically to gather information for recommendations to the House on their assigned subjects.

Members who have (usually accidentally) for the first time observed a session of the KMA House of Delegates have been known to depart with head shaking, muttering, "I could do better myself". That theory is undoubtedly true in many instances; unfortunately it can only be proven by demonstration, and too few seem willing to undertake the rather tedious laboratory work.

GEORGE F. BROCKMAN, M.D., SPEAKER
KMA HOUSE OF DELEGATES

Encouraging Signs

IF IT appeared in our local daily newspapers we failed to see any reference to a report in Barron's National Business and Financial Weekly of June 20, 1966. The article is entitled "Cradle to Grave?" with the subtitle "The British Are Turning Away from Socialized Medicine." There is the notation that it gives an on-the-scene account of the revival of private medical practice in the United Kingdom and was written by Neil McInnes, European correspondent for Barron's. Attention is directed to this article because it gives a somewhat different angle to Britian's medical care than we have been accustomed to read or hear. The article begins:

LONDON — By a curious coincidence, on July 1 the United States will take its first step toward socialized medicine and Britain will take its biggest step away from it. On the same day medicare goes into effect for senior American citizens, all British subjects, old or young, will be offered a paying alternative to the free National Health Service. A company called Independent Medical Services, Ltd., will seek to sell Britons for cash what they have been getting free from the welfare state for nearly two decades. In this apparently quixotic undertaking it enjoys the backing of the British Medical Association, of which the vast majority of this country's doctors are members.

* * *

Executives of Independent Medical Services recently told Barron's that public opinion surveys showed 30%-40% of Her Majesty's subjects are not satisfied with free cradle-to-grave state medicine. They would prefer to make private arrangements with a family doctor. The firm, for a moderate charge, will enable them to do just that. Public discontent with the National Health Service, however, had less to do with formation of Independent Medical Services than doctor dissatisfaction with their pay and working conditions. Disagreement between the Health Minister and the United Kingdom's 23,000 physicians on those matters has been chronic. The boiling point was reached early last month, when 18,000 doctors signed undated resignations from the National Health Service.

* * *

Currently, over two million Britons are covered by private health insurance, for which they or their employers pay regular subscriptions. The policies cover the cost of treatment in private nursing homes or in the single rooms and pay-beds of the nationalized hospitals. Most of these people subscribe to the British United Provident Association (BUPA), one of the more successful brain children of the late Lord Nuffield, maker of the Morris car. Independent Medical Services will not insure the cost of nursing home treatment, as BUPA does, but rather against family doctor bills and drug costs, which BUPA does not cover.

Even without Independent Medical Services, private medical schemes have been gaining 100,000 adherents a year. Subscribers to British United Provident are increasing at a rate of 75,000 annually. Two smaller concerns of the same kind, Hospital Services Plan in Tunbridge Wells and Western Provident in Bristol, are understood to be signing up another 28,000 a year between them. This rate of growth has surprised no one more than the managers of BUPA itself. Hence, they have commissioned a J. Walter Thompson subsidiary to do a market survey to find out just how many people in Britain are willing to pay for an alternative to free state medicine.

"We never dreamed this business could grow so far and so fast," says BUPA's Hugh Elwell, joint secretary in charge of development. "We kept thinking the boom would top out, but it didn't. Now we want to see how big the potential market is — five million people, 10 million, maybe more? While we're finding out, we are stepping up our advertising outlays from $28,000 to $132,000 a year. Most of our members have been won by word of mouth, but now we have decided to sell a little harder. Also, we've ordered a computer from De La Rue-Bull big enough to handle millions of subscribers."

* * *

Why are so many of Her Majesty's subjects willing to pay for medical care substantial sums in addition to those they have already paid, in taxes and in National Health stamps, for "free" care? Not only the rich are doing so. Those who are deserting state medicine are middle-class Britons and quite a few workers who cannot afford catastrophic medical bills, but are not content with socialized medicare.

Their complaints are precise. First, the average National Health doctor has 2,300 people on his list, which compares with one doctor for 752 peopole in the U.S. It means long, frustrating (and, for some, costly) hours in waiting rooms. Consultations often are so hasty that, rightly or wrongly, patients feel they are perfunctory. If a specialist is needed, the patient has no say in who will be consulted, nor where, nor when.

If the specialist is a surgeon and he recommends an operation, there is no guarantee that he will perform it himself. The scalpel may be wielded by a surgeon whom the patient has never seen before and may not see very often afterward. In short, many a sufferer gets the feeling he is on a conveyor belt in a very impersonal medical factory.

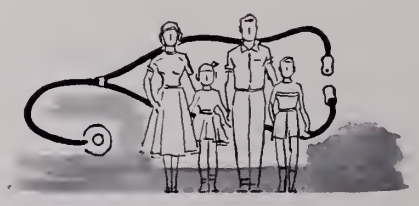
* * *

While eschewing politics, Independent Medical Services, Ltd., recently took a fling at philosophy. The introduction to the booklets it is distributing this month to advertise its appearance is not a citation from any Tory manual or Liberal manifesto. Rather, it quotes Abraham Lincoln: "You cannot build character and courage by taking away men's initiative and independence. You cannot help men permanently by doing for them what they could do for themselves."

In the present somewhat confused plight of American medicine the above quoted sections from Mr. Neil McInnes's observations are somewhat encouraging. About a year ago Charles J. Tupper, M.D., then Associate Dean of the University of Michigan School of Medicine and Editor of the Michigan Medical Journal wrote an article proposing to outline what he thought would be the state of medicine 50 years from now. One passage in that article caught our eye. It may not be significant, but again it may be prophetic. Dr. Tupper stated that within 50 years socialized medicine in America would have come and gone and medical care would again be on the basis of free and independent individual initiative.

We may look forward with hope.

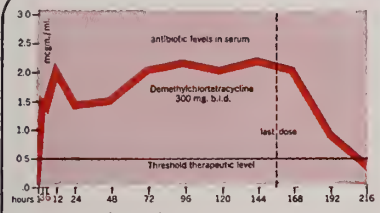
SAM A. OVERSTREET, M.D.





greater potency
lower mg intake per day
600 mg versus 1,000 mg

in G.U. infections
broad-spectrum performance



high activity

From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M.: Amer. J. Med. Sci. 243:296 (Mar.) 1962

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

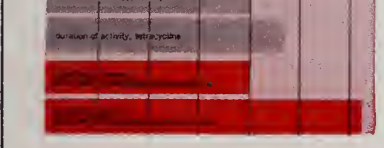
Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

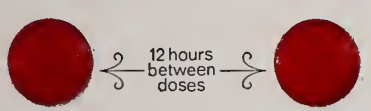
Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.



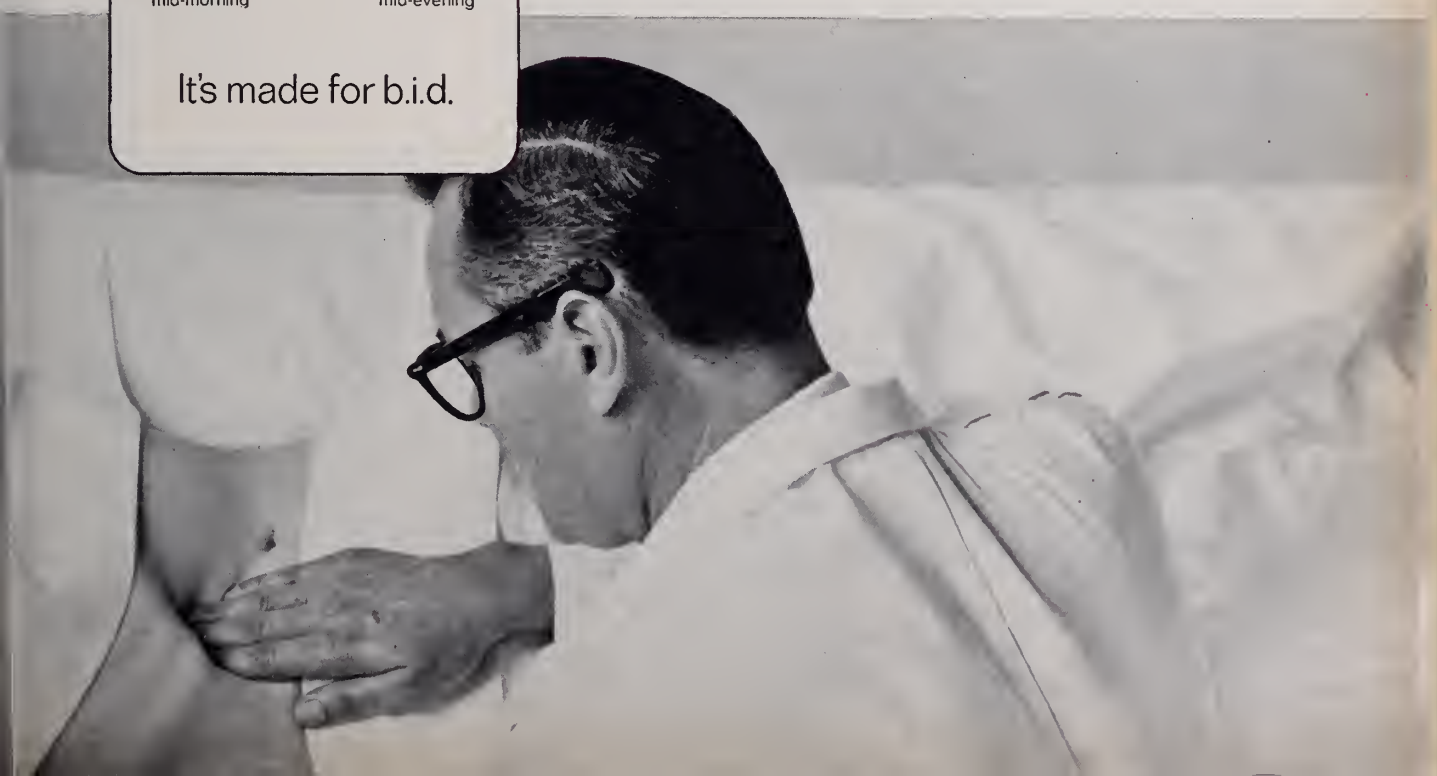
1-2 "extra" days' activity
after the last dose to protect against relapse



one 300 mg Tablet
mid-morning

one 300 mg Tablet
mid-evening

It's made for b.i.d.



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Annual Meeting Section

KMA OFFICERS 1965 — 1966





George W. Pedigo, M.D.
Vice-President (Central)



Donald K. Dudderar, M.D.
Vice-President (Eastern)



C. C. Lowry, M.D.
Vice-President (Western)

PRESIDENT-ELECT

Robert E. Pennington, M.D.

London, Ky.

Doctor Pennington, a vice-president of the Kentucky Medical Association from the Eastern district in 1961-1962, has also served as Chairman of the KMA Board of Trustees in 1964-65. He has been a member of the Board since 1963.

A native of London, Doctor Pennington received his B.A. degree from the University of Kentucky in 1931, and his M.A. degree from the University in 1932. He entered the University of Pennsylvania and received his medical degree in 1936. His internship was served at the Philadelphia General Hospital, Philadelphia from 1936 to 1938. From Pennsylvania, Doctor Pennington went to Ohio for two years, where he was an assistant in Pathology at the Institute of Pathology, Western Reserve University in Cleveland.

From January 1939 to July, 1941, Doctor Pennington was a Fellow in surgery at the Mayo Foundation, Rochester, Minn.; he was also a resident in surgery at the Mayo Clinic until April, 1942.

Doctor Pennington entered military service in 1942 as Captain in the U.S. Army. He was stationed at Ft. Warren, Wyo., Ft. Leavenworth, Kans., Ft. Leonard Wood, Mo., before serving at the China Theatre for two years as commanding officer of the 47th Portable Surgical Hospital. He was awarded the Bronze Star Metal in 1945, for meritorious service, and was discharged from service in 1946 as a Lieutenant Colonel.

Since that time, Doctor Pennington has been in private practice of surgery in London, where he served as Secretary of the Laurel County Medical Society. A member of the American Medical Association, other memberships include: Southern Medical Association, American College of Surgeons, and Southeastern Surgical Congress.

Doctor Pennington is active as a member of the Health Facilities Advisory Committee of the Commonwealth of Kentucky, and as a member of the Health Advisory Council to the Appalachian Regional Commission. He was named to the Kentucky Chamber of Commerce, London-Laurel County, and to the Board of Trustees, Sue Bennett College, London.

The KMA president-elect is an active participant in the affairs of his church and community. In addition to his work in the Methodist Church, Doctor Pennington is a member of the Kiwanis Club.

Doctor Pennington has an outstanding record of service in his work in medicine and in his community. This, coupled with his personal qualities of leadership, dedication, and integrity has made him the natural choice as president-elect.

VICE PRESIDENT, CENTRAL

George W. Pedigo, M.D., Louisville

The first physician ever appointed to serve on the Board of Directors of the Kentucky Chamber of Commerce (1959), Doctor Pedigo is a former associate editor of the Journal of KMA (1958-62) and a past vice speaker of the KMA House of Delegates (1956-59). He graduated from the University of Louisville School of Medicine in 1938. In 1960 he served as president of the Jefferson County Medical Society and also had served the society as secretary and treasurer. An internist, he is a member of the American College of Physicians, a diplomate of the American Board of Internal Medicine, and associate clinical professor of medicine at U of L School of Medicine.

VICE PRESIDENT, EASTERN

Donald K. Dudderar, M.D., Newport

A graduate of the University of Louisville School of Medicine in 1947, Doctor Dudderar is a past president and past secretary of the Campbell-Kenton County Medical Society. He has been in private practice as a urologist in Newport since December 1954. Following residency training at Orangeburg Regional Hospital, Orangeburg, So. Carolina, he served with the U. S. Army as chief of urology at Camp Roberts and Camp Stoneman in California. A native of Stanford, he is currently a member of the Ft. Thomas Lion's Club. Doctor Dudderar is a member of the Southeastern section of the American Urological Association.

VICE PRESIDENT, WESTERN

C. C. Lowry, M.D., Murray

Doctor Lowry, a former president of the Calloway County Medical Society, graduated from the University of Kentucky in 1940 and from Vanderbilt University School of Medicine in 1943. Following his internship and some residency training at Vanderbilt, he served in the U. S. Army Medical Corps. In July 1947 he returned to complete his residency in surgery at Kennedy Veteran's Administration Hospital in Memphis. Since 1952 he has maintained a practice limited to general surgery at Murray. He is a member of the American College of Surgeons and the Kentucky Surgical Society. Doctor Lowry is a past president of the Murray Lions Club, a member of the Murray Board of Education and a member and steward of the First Methodist Church in Murray.

KMA Secretary and Treasurer

SECRETARY

Henry B. Asman, M.D., Louisville



Doctor Asman, serving as Secretary of the KMA since 1963, was formerly vice-president (1961-63) of the Association. He is also a past president of the Kentucky Division of the American Cancer Society. Doctor Asman, a 1936 graduate of the University of Louisville School of Medicine, is a Fellow of the American College of Surgeons, and the Southeastern Surgical Congress. He returned to private practice in coloproctology after his discharge from the U.S. Army Medical Corps in 1946. Doctor Asman has been appointed to the staff of several local hospitals.

TREASURER

Keith P. Smith, M.D., Corbin



Treasurer of the Kentucky Medical Association since 1963, Doctor Smith has been active in KMA affairs for many years. He served as KMA trustee (then councilor) from 1957 until elected to his current post, and in 1962-63 was chairman of the Board of Trustees. Doctor Smith is a 1936 graduate of the University of Louisville School of Medicine. He has served as a KMA vice-president and is a former president and vice-president of the Kentucky Chapter of the American Academy of General Practice. Dr. Smith is active in local County Medical Society and Civic activities.

KMA Journal Editors

EDITOR

Sam. A. Overstreet, M.D., Louisville



President of KMA during its Centennial in 1950-51 and a former speaker of the KMA House of Delegates, Doctor Overstreet has served as editor of *The Journal* for eight years. A past governor of the Kentucky Chapter, American College of Physicians, he is also a past president of the Jefferson County Medical Society. A clinical professor of medicine at the University of Louisville School of Medicine, Doctor Overstreet received his M.D. degree there in 1923. Before he was named editor of *The Journal,* he was the medical editorial editor for several years.

ASSOCIATE EDITOR

Walter S. Coe, M.D., Louisville



Doctor Coe, a graduate of the University of Louisville School of Medicine in 1943, was recently re-elected president of the Kentucky Heart Association. He assumed his position as associate editor of *The Journal* in 1962, after many years as book review editor. An associate clinical professor of medicine at the University of Louisville School of Medicine, he has served as a director of the Kentucky Heart Association and is a past president of the Louisville and Jefferson County Heart Association and the Kentucky Society of Internal Medicine.

AMA Delegates

J. Thomas Giannini, M.D., Louisville



Elected as delegate from KMA to AMA in 1963, Doctor Giannini previously served the Association as an alternate delegate to AMA and as chairman of the Scientific Exhibits Committee. He represented the Jefferson County Medical Society on the KMA House of Delegates before he was named alternate delegate to AMA. After graduating from the University of Louisville School of Medicine in 1938, he served in the U.S. Navy Medical Corps from 1942-54. Doctor Giannini, a Fellow of the American Society of Plastic and Reconstructive Surgeons, limits his practice to plastic and reconstructive surgery.

John C. Quertermous, M.D., Murray



Serving as an alternate delegate to the AMA until being elected delegate in 1963, Doctor Quertermous is currently chairman for national affairs of the KMA Council on Legislative Activities. He has also served KMA as a member of its Committee on Aging, and the Committee on Postgraduate Medical Education. An internist, he is a past president of the Calloway County Medical Society and in 1960 served on the Governor's Citizens Committee on Problems of Aging. Doctor Quertermous, who served in the Army Medical Corps from 1943 to 1946, graduated in 1942 from the University of Louisville School of Medicine.

AMA Delegate

Charles C. Rutledge, M.D., Hazard

Doctor Rutledge, who graduated from the University of Louisville School of Medicine in 1946, was elected a delegate to the AMA at the 1965 Annual Meeting. He was formerly an alternate delegate to KMA, past president of the Pike and Perry Counties Medical Societies, and a past Councilor of the KMA. For four years he was district chairman for KEMPAC and was also a district keyman for KMA. A member and past councilor of the Kentucky chapter, American College of Surgeons, Doctor Rutledge is also a Fellow of the American College of Surgeons and past associate councilor of the Southern Medical Association.



New Trustees

Joseph R. Miller, M.D., Benton

Doctor Miller, a former vice-president (Western) of KMA, graduated from the University of Louisville School of Medicine in 1942, and interned at Baroness Erlanger Hospital, Chattanooga, Tenn. He has attended sessions at Cook County Graduate School of Medicine. Active in medical activities, he was elected president of the Marshall County Medical Society on three different occasions. Doctor Miller has been a director of the First District of the Kentucky Academy of General Practice.

Henry S. Spalding, M.D., Bardstown

Doctor Spalding, a 1957 graduate of the University of Louisville School of Medicine, has been practicing in Nelson County since receiving his Kentucky license in 1957. He is a general practitioner. Doctor Spalding is an active member of the American Academy of General Practitioners, and of the Kentucky Academy of General Practitioners.

Robert F. Long, M.D., Somerset

A graduate of the Tulane University School of Medicine, New Orleans, La. in the class of 1948, Doctor Long has been in practice in Pulaski County for 13 years. Prior to that time, he worked in radiology at the Johns Hopkins Hospital, Baltimore, Md., and was given a National Cancer Research Scholarship in 1952. Doctor Long, a member of the Southern Medical Association, is a diplomate of the American Board of Radiology, and of the Radiology Section of Pan-American Medical Association. He is also a member of the American College of Radiology, the Interamerican, International, and the North American Colleges of Radiology.

James W. Archer, M.D., Paintsville

(Biographical information on the late James W. Archer, M.D., Paintsville, may be found on page 962, in the Organization Section.)

Ellsworth C. Seeley, M.D., London

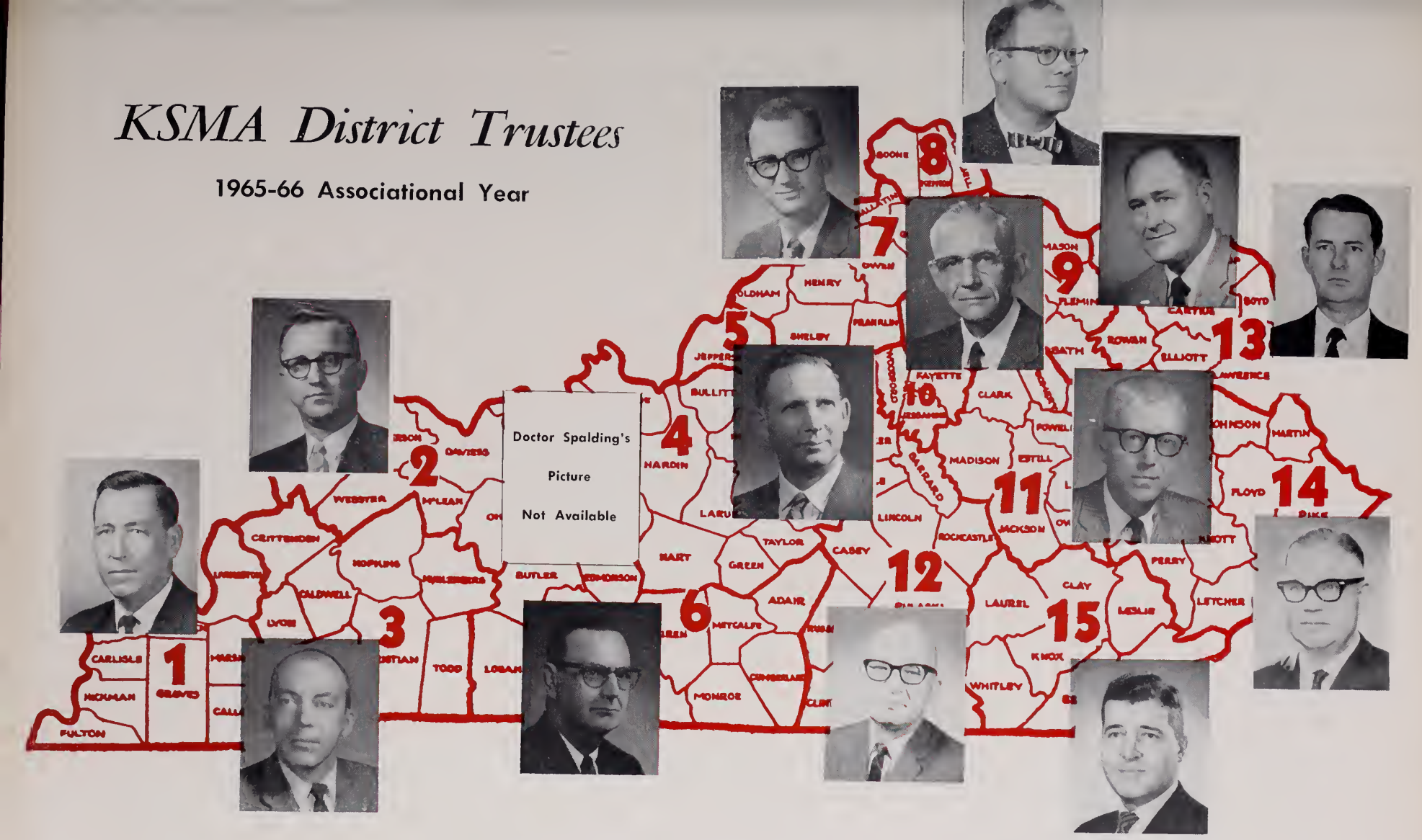
Doctor Seeley, a general practitioner in London since 1951, is a past president of the KAGP and served on the Board of KAGP from 1959 until 1965. A 1947 graduate of the University of Louisville Medical School, Doctor Seeley is active in the Laurel County Medical Society and has served the society as president and secretary. He is on the Laurel County Board of Health and has served as president and secretary of the staff of Marymount Hospital. From 1943-46 he served in the U.S. Army and was commissioned in the U.S. Naval Reserve Medical Corps from 1949-51.

Election of Trustees

The House of Delegates will elect five trustees for the regular three-year term and one trustee to fill the unexpired term of the late James W. Archer, M.D., Paintsville, at its second session on Wednesday, September 21. The delegates from each trustee district serve as the nominating committee for that district and will meet immediately after the first session of the House on September 19. At the close of the first scientific session on Tuesday, September 20, the committee will report its nominees. Further nominations may be made from the floor at the final meeting of the House of Delegates, Wednesday evening, September 21. All nominations are considered and acted upon by the delegates at this final session of the House. Districts electing new trustees for three-year terms are: **Fifth District** (incumbent, A. O. Miller, M.D., Louisville); **Sixth District** (incumbent, Rex E. Hayes, M.D., Glasgow); **Eighth District** (incumbent, W. Donald Janney, M.D., Covington); **Eleventh District** (incumbent, Hubert C. Jones, M.D., Berea); and **Fifteenth District** (incumbent, E. C. Seeley, M.D., London). The new trustee in the **Fourteenth District** will be elected to fill the unexpired term of the late Doctor Archer and will serve until 1968. Doctors Miller, Hayes, and Janney have served only one full term and are eligible for re-election. Doctor Seeley filled the unexpired term of R. E. Pennington, M.D., London, who in 1965 was made President-Elect, and he is also eligible for re-election.

KSMA District Trustees

1965-66 Associational Year



1. JOSEPH R. MILLER
Benton

2. W. GERALD EDDS
Calhoun

3. GABE A. PAYNE, JR.
Hopkinsville

4. HENRY S. SPALDING
Bardstown

5. ALFRED O. MILLER
Louisville

6. REX E. HAYES*
Glasgow

7. DONALD CHATHAM
Shelbyville

8. W. DONALD JANNEY*
Covington

9. MITCHEL B. DENHAM
Maysville

10. DOUGLAS E. SCOTT
Lexington

11. HUBERT C. JONES*†
Berea

12. ROBERT F. LONG
Somerset

13. WALTER L. CAWOOD*
Ashland

14. JAMES W. ARCHER
Paintsville (deceased)

15. E. C. SEELEY
London

†*Chairman of the Board*
**Member of the Executive Committee*

Officers of the KMA House of Delegates

SPEAKER

George F. Brockman, M.D., Greenville



Elected as the vice-speaker of the KMA House of Delegates in 1962, Doctor Brockman has served as a member of several KMA committees, the most recent ones being committees on Public Education, Scientific Assembly and Maternal Mortality. Formerly chairman of the KMA Building Committee, and the Building Study Committee, he was also chairman of the Advisory Committee to the Editor of The Journal. In 1961 he was appointed as delegate to the AMA, and served until the end of that year. Doctor Brockman, a 1935 graduate of the U. of L. School of Medicine, is secretary of the Muhlenberg County Medical Society.

VICE-SPEAKER

Richard F. Greathouse, M.D., Louisville



Doctor Greathouse, newly elected to his office in 1965, has served as a past delegate to KMA from the Jefferson County Medical Society and was re-elected in 1965. Presently, he is secretary-treasurer of KEMPAC, being elected in 1965. Doctor Greathouse is President of the Louisville Pediatric Society and vice-chairman of the Kentucky Chapter of the American Academy of Pediatrics. He is Chairman of the Pediatric Section at Methodist Hospital and past president of the staff at Children's Hospital; also active on the staff of St. Joseph Infirmary, Methodist Hospital and Children's Hospital.

KMA Delegates

ADAIR
J. C. Salato, Columbia

ALLEN
F. J. Halcomb, Jr., Scottsville

ANDERSON
Boyd Caudill, Lawrenceburg

BALLARD
Glenn Baird, Bandana

BARREN
E. L. Marion, Glasgow

BATH

BELL
Meredith Evans, Middlesboro

BOONE
L. C. Hess, Florence

BOURBON
James L. Ferrell, Paris

BOYD
J. S. Wheeler, Ashland
J. E. Stephenson, Ashland
John Ashworth, Ashland

BOYLE
John Baird, Danville

BRACKEN
J. M. Stevenson, Brooksville

BREATHITT
Robert E. Cornett, Jackson

BRECKINRIDGE
James G. Sills, Hardinsburg

BULLITT
James Roney, Lebanon Junction

BUTLER
D. G. Miller, Morgantown

CALDWELL
Frank P. Giannini, Princeton

CALLOWAY
Thomas L. Parker, Murray

CAMPBELL-KENTON
C. J. Brueggemann, Covington
Donald K. Dudderar, Newport
W. Vinson Pierce, Covington
Thomas L. Heavern, Newport
P. H. Klingenberg, S. Ft. Mitchell
Robert Longshore, Covington

CARLISLE
John T. O'Neill, Arlington

CARROLL
E. S. Weaver, Carrollton

CARTER

CASEY
Garnett Sweeney, Liberty

CHRISTIAN
W. Faxon Payne, Hopkinsville
Norma T. Shepherd, Hopkinsville

CLARK
Harold Moberly, Winchester

CLAY
W. E. Becknell, Manchester

CLINTON
Ernest A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND
R. B. Chambliss, Burkesville

DAVIESS
Reginald J. Phillips, Owensboro
William W. Hall, Owensboro

EDMONSON

ELLIOTT
John F. Greene, Sandy Hook

ESTILL
Virginia Wallace, Irvine

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W. L. Blakey, Lexington
N. L. Bosworth, Lexington
T. R. Bryant, Jr., Lexington
John E. Myers, Lexington
J. H. Saunders, Lexington
R. D. Shepard, Lexington

FLEMING
S. W. Gehring, Flemingsburg

FLOYD
James D. Adams, Prestonsburg

FRANKLIN
S. L. Weiler, Frankfort
Harry Cowherd, Frankfort

FULTON
R. W. Bushart, Fulton

GALLATIN

GARRARD
Paul E. Lett, Lancaster

GRANT
Lenore Chipman, Williamstown

GRAVES
A. Reeves Morgan, Mayfield

GRAYSON
C. L. Bland, Leitchfield

GREEN
R. P. Simmons, Greensburg

GREENUP
John O. Jones, Flatwoods

HARDIN
F. C. Rainey, Elizabethtown

HARLAN
Henry C. Evans, Harlan
Doane Fischer, Harlan

HARRISON
Henry H. Moody, Cynthiana

HART

HENDERSON
Charles Kissinger, Henderson

HENRY

HICKMAN
C. J. Mills, Clinton

HOPKINS
Loman Trover, Madisonville

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JEFFERSON
Sam Black, Louisville
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John Doyle, Louisville
Robert McClendon, Louisville

Henry Post, Louisville
W. Fielding Rubel, Louisville
W. T. Rumage, Jr., Louisville
William Stodghill, Louisville
John Wolford, Louisville
Eugene H. Conner, Louisville
Louis Foltz, Louisville
R. F. Greathouse, Louisville
John Harter, Louisville
John Harter, Louisville
W. I. Hume, Jr., Louisville
Herman Moore, Louisville
K. P. Crawford, Louisville
Gerald Peterson, Louisville
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William Durham, Louisville
John Goldsborough, Louisville
John Hemmer, Louisville
Herman Mahaffey, Louisville
William Mitchell, Louisville
John Robbins, Louisville
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Donald Varga, Louisville
William VonderHarr, Louisville
Lloyd Yopp, Louisville

JESSAMINE
J. S. Williams, Nicholasville

JOHNSON
A. B. Carter, Paintsville

KNOTT
G. T. Watts, Hindman

KNOX
H. L. Bushey, Barbourville

LARUE
Marion Douglas, Magnolia

LAUREL
Paul R. Smith, London

LAWRENCE
William J. McNabb, Louisa

LEE

LETCHER
J. B. Tolliver, Whitesburg

LESLIE

LEWIS

LINCOLN
E. C. Bowling, Stanford

LIVINGSTON

LOGAN

LYON
J. E. Hamilton, Eddyville

McCRACKEN
Winfield Stryker, Paducah

McCREARY
H. A. Perry, Sterns

McLEAN
Samuel Scott, Livermore

MADISON
William D. Epling, Berea
Doublas Jenkins, Berea

MAGOFFIN

MARION
John W. Ratliff, Lebanon

MARSHALL
Wendell Gordon, Benton

MARTIN
John W. Ford, Inez

MASON
H. N. Parker, Maysville

MEADE
George E. Clark, Brandenburg

MENIFEE
D. L. Graves, Frenchburg

MERCER
Bacon R. Moore, III, Harrodsburg

METCALFE
L. P. Emberton, Edmonton

MONROE
W. R. Breshong, Tomkinsville

MONTGOMERY
R. J. Salisbury, Mt. Sterling

MORGAN
George Bellamy, West Liberty

MUHLENBERG
Robert Robbins, Greenville

NELSON
James Millen, Bardstown

NICHOLAS
W. R. Kingsolver, Carlisle

OHIO
Robert T. Johnson, Beaver Dam

OLDHAM
James Kurfees, Crestwood

OWEN

OWSLEY

PENDLETON
R. L. McKenney, Falmouth

PERRY
Mary Fox, Hazard

PIKE
Harvey A. Page, Pikeville

POWELL
Charles Noss, Stanton

PULASKI
Barton L. Ramsey, Somerset
William M. Wyatt, Somerset

ROBERTSON

ROCKCASTLE
G. H. Griffith, Mt. Vernon

RUSSELL
C. E. Peck, Russell Springs

SCOTT
J. C. Cantrill, Georgetown

SHELBY
Stephen F. Collins, Shelbyville

SIMPSON
A. V. Wilwayco, Franklin

SPENCER
William K. Skaggs, Taylorsville

TAYLOR
M. M. Hall, Campbellsville

TODD
J. C. Woodall, Trenton

TRIGG
Elias N. Rutrell, Cadiz

TRIMBLE
Carl Cooper, Bedford

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Martin Wilson, Bowling Green
Paul J. Parks, Bowling Green

WASHINGTON
Harold B. Simms, Springfield

WAYNE
Robert B. Breeding, Monticello

WEBSTER
Paul Taylor, Providence

WHITLEY
Harold B. Barton, Corbin

WOLFE
Paul F. Maddox, Campton

WOODFORD
Ben F. Roach, Midway

County School Health Chairmen To Meet September 22

Fred V. Hein, Ph.D., Chicago, director of the AMA Department of Health Education, will be the featured speaker at a meeting for all County School Health Chairmen, Thursday, September 22, at the KMA Annual Meeting, according to O. B. Murphy, M.D., Lexington, chairman of the KMA School Health Committee.

"School Health in Action" will be the title of Doctor Hein's presentation, which will be given at 2:00 p.m. in room 208 of the Convention Center. A movie on the same subject of school health activities will be shown following Doctor Hein. The responsibility of medical society School Health Chairmen will also be discussed.

All KMA members interested in school health programs are encouraged to attend.

Legislative Workshop Featured At Woman's Auxiliary Meeting

A legislative workshop will be held September 19, as a part of the annual meeting of the Woman's Auxiliary to the KMA, which will open the following day at the Kentucky Hotel.

The workshop, sponsored by KEMPAC, will be conducted by Mrs. Harry Fry and Mrs. George Griffin, both of Cincinnati. The session will begin at 2:00 p.m. Monday afternoon.

Designed for County presidents and legislative chairman, the workshop is for the benefit of local auxiliaries throughout Kentucky, and all interested WA-KMA members are cordially invited to attend.

As this is an election year in Kentucky, this workshop should prove to be most interesting and beneficial to all Kentuckians.

Reference Committee Activity

All officers' and committees' reports and resolutions will be referred to one of seven reference committees by Speaker George F. Brockman, M.D., Greenville, at the **first meeting of the KMA House of Delegates on Monday, September 19, at 9 a.m.** Members of the reference committees will meet for briefing sessions on Monday at 12:30 p.m. in Parlor B, Kentucky Hotel. **Any KMA member wishing to testify on any resolution or report is urged to be present at 2 p.m. on Monday, September 19, when reference committees will meet on the mezzanine floor of the Kentucky.** These open sessions will last at least an hour in order to permit all who wish to speak to be heard. The committees will go into executive sessions following the open hearings to study the reports, review the testimony and write its report to the House.

At the final session of the House on Wednesday night, September 21 in the Terrace Room of the Kentucky, the committees' recommendations will be made. Reference committees appointed by Doctor Brockman to serve during the 1966 session follow.

1966 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1
Officers and Board of Trustees

Mary Pauline Fox, M.D., Hazard, chairman
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Donn L. Smith, M.D., Louisville, chairman
Graydon A. Long, M.D., Lexington
C. J. Brueggemann, M.D., Covington

Nominating Committee Meeting Set for Monday, Sept. 19

The KMA Nominating Committee will hold an open meeting following the close of the first session of the House of Delegates on Monday morning, September 19.

At that time members wishing to confer with the committee may do so. Location of the open meeting wll be announced later.

At the end of the first scientific session on Tuesday morning, September 20, the Committee's final recommendations will be reported. Other nominations may be made from the floor at the House of Delegates meeting on Wednesday evening, September 21. The House will vote on the nominees at the close of the second session on Wednesday.

W. Vinson Pierce, M.D., Covington, is chairman of the Nominating Committee. Other members are: Harold B. Barton, M.D., Corbin; Ballard M. Cassady, M.D., Pikeville; Irving F. Kanner, M.D., Lexingington; and William T. Rumage, Jr., M.D., Louisville.

Annual Meeting Special Features



The Kentucky Hotel
KMA Annual Meeting Headquarters

SCIENTIFIC SESSIONS featuring prominent guest speakers and closed circuit color television seminars are scheduled on September 20, 21, and 22 at the Convention Center in Louisville. The television panels will consider a variety of subjects, including, "Erythroblastosis Fetalis", "Management of Infections", "Drugs" and "Pelvic Laparotomy".

SEVENTY-FIVE TECHNICAL EXHIBITS will display new developments in pharmaceuticals, equipment, instruments, and medical literature. You will have an opportunity to view products which should be of vital interest to today's busy practitioners at 30-minute intermissions which have been scheduled during each general and specialty group session.

THE HOUSE OF DELEGATES—KMA's policy-making body—will meet twice during the 1966 Annual Meeting—on Monday morning, September 19 at 9 a.m. and on Wednesday evening, September 21 at 7 p.m. Officers for 1966-67 will be elected at the final session. Both sessions will be held in the Terrace Room of the Kentucky Hotel.

SIXTEEN SPECIALTY GROUPS will hold their meetings in conjunction with the KMA meeting. Eight specialty groups will meet Tuesday afternoon, September 20 and eight on Thursday, September 22. Guest lecturers as well as some local physicians are scheduled to address the groups. No general session is scheduled for either Tuesday or Thursday afternoon. All KMA members are invited to attend these meetings.

THE PRESIDENT'S LUNCHEON will have Walter H. Judd, M.D., well known former Congressman, medical missionary, and lecturer, who will speak on "Can the Best be Better?" Doctor Judd will be remembered by many as the keynote speaker at the 1960 Republican Convention. KMA's three top awards will also be presented at the luncheon.

ALUMNI REUNIONS, long a tradition at KMA Annual Meetings, will be held by five-year classes of the University of Louisville School of Medicine. A special feature of this year's reunions will be special hospitality tours of the U of L medical school on Tuesday, September 20 from 4 to 6 p.m. Other reunion plans were incomplete at press time.

OFFICIAL CALL

KMA Annual Meeting

To the officers and members of the component county medical societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KMA will convene at the Convention Center, Louisville, on Tuesday, Wednesday, and Thursday, September 20, 21, and 22. The first general session will be called to order at 8:50 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 9 a.m., Monday, September 19. The second regular business session will begin at 7 p.m. Wednesday, September 21. Both sessions will be held in the Terrace Room of the Kentucky Hotel.

Registration

The registration desk will open at the Terrace Room of the Kentucky Hotel at 8 a.m. on Monday, September 19 and at 5:30 p.m., Wednesday, September 21. It will be open in the technical exhibit hall of the Convention Center from 8 to 5 p.m. on Tuesday, September 20; Wednesday, September 21; and Thursday, September 22.

Annual Meeting Woman's Auxiliary to the KMA

Registration

Lobby, Kentucky Hotel
Monday 12 Noon—5:00 PM
Tuesday 7:30 AM—5:00 PM
Wednesday 9:00 AM—11:00 AM
(all times are Eastern Standard)

Pre-Convention Legislative Workshop Room 1510 Monday, September 19, 2 PM-4 PM

Mrs. Harry Fry and Mrs. George Griffin, Cincinnati, conductors assisted by Mrs. A. S. Holmes, Legislative Chairman and sponsored by KEMPAC.

Tuesday, September 20

Continental Breakfast, Room 312 from 8AM-10AM.

Pre-convention Board Breakfast (subscription): 8 AM, Parlor B, Kentucky Hotel. All general officers, chairmen of standing and special committees, three immediate past presidents, councilors, co-ordinator for Members-at-Large and county auxiliary presidents are urged to attend.

Formal Opening of Convention: 10 AM, Mirror Room, Kentucky Hotel

Luncheon (subscription) honoring past presidents, members-at-large and distinguished guests, 12:30 PM Terrace Room.

Formal Convention Session: 2 PM.

Wednesday, September 21

Continental Breakfast, Hospitality Room, 312, 8 AM-9:15 AM.

Formal Convention Session: 9:15 AM, Mirror Room, Kentucky Hotel.

Luncheon-Fashion Show (subscription) honoring Mrs. Karl Ritter, President-Elect, Woman's Auxiliary to the AMA: 12:30 PM, Flag Room.

Gavel Club Dinner for Past State Presidents: 7 PM.

Thursday, September 22

Post-convention Board Breakfast (subscription): 8:45 AM, Parlor A.

VISIT THE HOSPITALITY ROOM AND HOBBY SHOW IN ROOM 312 KENTUCKY HOTEL.

Dr. Walter Judd to Speak Sept. 21 At President's Luncheon

Walter H. Judd, M.D., a nationally recognized authority on U.S. foreign policy who served ten terms in the U.S. Congress, will be the keynote speaker at the 1966 KMA President's Luncheon at the Kentucky Hotel, Wednesday, September 21.


Doctor Judd

"We are most fortunate to have a speaker of Doctor Judd's calibre for this year's luncheon," said Everett H. Baker, M.D., KMA President, when he announced Doctor Judd's acceptance, "and we know Kentucky physicians will be interested in hearing such an outstanding speaker".

His topic will be, "Can the Best be Better?"

Doctor Judd was a member of the Foreign Affairs Committee for 16 years, a delegate to the General Assembly of the U.N. in 1957, and to the World Health Organization Assembly in 1950 and 1958. During his 20 years in Congress he authored or sponsored innumerable laws.

Doctor Judd lived 10 years in China as a medical missionary. During his lifetime he has received numerous honors including the AMA Distinguished Service Award, CARE-MEDICO World Humanitarian Award, and the U.S. Chamber of Commerce Great Living American Award.

Doctor Judd speaks to interested groups all over the country and has appeared on many nationwide radio and TV programs. He was keynote address at the Republican National Convention in 1960.

He will speak following the luncheon which is scheduled for 11:50 a.m. in the Terrace Room of the Kentucky Hotel.

1966 Annual Meeting Program Summary

The Kentucky Medical Association

September 18, 19, 20, 21, and 22

Louisville

SUNDAY, SEPTEMBER 18

12:30 p.m.	Luncheon Meeting, KMA Board of Trustees	Parlor A, Kentucky Hotel
6:30 p.m.	Dinner Meeting, Board of Directors, Ky. Physicians Mutual	Ship Room, Kentucky Hotel

MONDAY, SEPTEMBER 19

8:30 a.m.	Orientation Program, New KMA Members	Mirror Room, Kentucky Hotel
9:00 a.m.	First Meeting, KMA House of Delegates	Terrace Room, Kentucky Hotel
12:30 p.m.	Luncheon for Reference Committee Chairmen	Room 317, Kentucky Hotel
2:00 p.m.	Reference Committee Meetings	Parlors A, B, C, D—Rooms 203, 4 & 5, Kentucky Hotel
6:00 p.m.	KEMPAC Reception, Banquet and Seminar	Flag Room, Kentucky Hotel

TUESDAY, SEPTEMBER 20

8:00 a.m.	Registration	Technical Exhibit Hall, Convention Center
8:50 a.m.	Opening Ceremonies	Scientific Assembly Hall, Convention Center
9:00 a.m.	First Scientific Session and Color TV	Scientific Assembly Hall, Convention Center
2:00 p.m.	Specialty Group Sessions, Convention Center *(Eight Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session at this time. See pages 678 & 679 in program.)*	

WEDNESDAY, SEPTEMBER 21

9:00 a.m.	Second Scientific Session and Color TV	Scientific Assembly Hall, Convention Center
11:50 a.m.	President's Luncheon	Terrance Room, Kentucky Hotel
2:00 p.m.	Third Scientific Session and Color TV	Scientific Assembly Hall, Convention Center
5:00 p.m.	Meeting, Board of Trustees	Parlor B—Dinner at 6:00, Parlor A, Kentucky Hotel
6:00 p.m.	Subscription Dinner and Meeting, House of Delegates	Terrace Room, Kentucky Hotel

THURSDAY, SEPTEMBER 22

9:00 a.m.	Fourth Scientific Session and Color TV	Scientific Assembly Hall, Convention Center
12:00 noon	Board of Trustees Luncheon and Afternoon Meeting	Parlor A, Kentucky Hotel
2:00 p.m.	Specialty Group Sessions, Convention Center *(Eight Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session. See pages 682 & 683 in program.)*	
2:00 p.m.	Meeting of County School Health Chairmen	Room 208, Convention Center

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting Scientific and Technical Exhibits.

(Full Scientific Program Starts on page 678.)

The Kentucky Medical Association

SCIENTIFIC PROGRAM

Joseph Potts Thomas Memorial Meeting

Convention Center, Louisville

TUESDAY, SEPTEMBER 20
MORNING SESSION

General Session

Everett H. Baker, M.D., Louisville, KMA President, Presiding

Theme—"Recent Advances in Fetal and Neonatal Problems"

8:50 **Opening Ceremonies**
Welcome—Hoyt D. Gardner, M.D., Louisville
Invocation—To be announced

9:00 **"Neonatal Kidney Function"**
Chester C. Winter, M.D., Columbus, Ohio

9:20 **"Premature Rupture of the Membranes and Effect on the Fetus"**
Willis E. Brown, M.D., Little Rock, Ark.

9:40 **"The Undergrown Infant and Neonatal Hypoglycemia"**
Thomas K. Oliver, Jr., M.D., Seattle, Wash.

10:00 **Visit Exhibits**

10:30 **President's Address**
Everett H. Baker, M.D.

10:50 **Color TV Clinic: "Modern Concepts in Pathogenesis, Prevention, and Treatment of Erythroblastosis Fetalis"**
B. F. Andrews, M.D., Louisville, Moderator
John L. Duhring, M.D., Lexington
John G. Gorman, M.D., New York, N.Y.
Thomas K. Oliver, Jr., M.D., Seattle, Wash.

TUESDAY, SEPTEMBER 20
AFTERNOON SESSION

Specialty Group Meetings

(There will be no General Scientific Session on Tuesday Afternoon. Eight Specialty Groups will meet at that time. All KMA members are cordially invited to attend any of these meetings.)

Kentucky Chapter, American College of Chest Physicians

(Meeting jointly with the Kentucky Thoracic Society)

Room 104 — Convention Center

Fireside Conferences

2:00 **"Clinical Cardiology"**
John Thomas Reeves, M.D., Lexington, and Armond Tevia Gordon, M.D., Louisville, Moderators

CHESTER C. WINTER, M.D.

Columbus, O.



Professor of surgery/urology, Ohio State University and director of urology at University Hospital and Children's Hospital, Columbus. Former assistant professor of surgery and urology, University of California at Los Angeles, and acting head, division of urology, UCLA. M.D., State University of Iowa, 1946. Prize essayist, American Urological Association, 1956 and 1957; first prize for urological exhibits, AUA, three years; Winsbury-White lecturer, Royal Society of Medicine, London, 1965. Abstractor for Urological Survey publication; international editor for Nuclear Medicine in Excerpta Medica, 1964.

WILLIS E. BROWN, M.D.

Little Rock, Ark.



Professor and head, department of obstetrics and gynecology, University of Arkansas Medical Center. Former teaching appointments at the Universities of Michigan, Nebraska and Iowa. M.D., 1934, and M.S., 1939, University of Michigan. Former member of executive board of American College of Obstetricians and Gynecologists, 1951-64 and first vice-president, 1963-64; section chairman, AMA, 1962-63; section chairman, SMA, 1952-53; director of postgraduate medicine, University of Arkansas, 1949-56; currently on editorial boards of Southern Medical Journal and Fertility and Sterility.

THOMAS K. OLIVER, M.D.

Seattle, Wash.



Professor of pediatrics and head of the division of neonatal biology, University of Washington College of Medicine. Former instructor in pediatrics, Cornell University, and medical director of The Premature Institute, New York Hospital-Cornell Medical Center; former director, regional respirator center, Children's Hospital, Columbus, O., and director of pulmonary laboratory, department of pediatrics, Children's Hospital and Ohio State. Director of newborn service, Ohio State University Hospital. M.D., Harvard, 1949 Fellow, American Academy of Pediatrics; member Society for Pediatric Research, and others.

2:30 **"Tuberculosis and Fungus Diseases"**
Michael L. Furcolow, M.D., Lexington, and I. Zapolsky, M.D., Louisville, Moderators

3:00 **Visit Exhibits**

3:30 **"Electrocardiography and Vectorcardiography"**
Borys Surawicz, M.D., Lexington, and Leonard Leight, M.D., Louisville, Moderators

4:00 **"X-Ray Diagnostic Problems"**
Arthur Lieber, M.D., Lexington, and Thomas R. Marshall, M.D., Louisville, Moderator

4:30 **"Obstructive Airway Disease"**
Richard P. O'Neill, M.D., Lexington, and William Anderson, M.D., Louisville, Moderators

Kentucky Chapter, American College of Physicians

Room 203 — Convention Center

2:00 **"Intermittant Claudication of the Arms" (A report of six cases)**
John L. Wolford, M.D., Louisville

2:20 **"Abdominal Pain Due to Filariasis"**
Henry C. Evans, Jr., M.D., Harlan

2:40 **"Some Aspects of Diabetic Visceropathy"**
Paul Mandelstam, M.D., Lexington, with Arthur Lieber, M.D., Lexington

3:00 **Visit Exhibits**

*3:30 **"A Practical Approach to the Systemic Fungus Infections"**
Samuel Saslaw, M.D., Columbus, Ohio

4:00 **"Hypoprothrombinemic Hemopericardium in the Absence of Organic Heart Disease"**
Stuart Graves, M.D., Louisville

Kentucky Industrial Medical Association

Room 205 — Convention Center

2:00 **"Life on the Ocean Bottom"**
George F. Bond, M.D., Washington, D.C.

3:00 **Visit Exhibits**

3:30 **"Medical Mission to Afghanistan"**
Charles C. Kissinger, M.D., Henderson

Kentucky Orthopaedic Society

Room 204 — Convention Center

2:00 **"Anterior Lumbar Fusion"**
Wayne Kotcamp, M.D., Louisville

2:30 **"New Approach to Surgery of the Spine"**
John S. Collis, M.D., Cleveland, Ohio

3:00 **Visit Exhibits**

3:30 **"Manifestations of Skeletal Diseases in the Head and Neck"**
Howard H. Steel, M.D., Philadelphia, Pa.

4:00 **"A Study in the Dynamics of Knee Menisci"**
Richard Pitner, M.D., Lexington
O. B. Murphy, M.D., Lexington
David Stevens, M.D., Lexington

4:30 **Business Meeting**

**Sponsored in part by the education program of Warner-Chilcott Laboratories.*

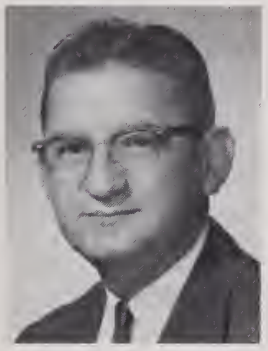
JOHN C. GORMAN, M.D.
New York, N.Y.



Director of Blood Bank, Presbyterian Hospital, New York; associate in pathology, Columbia University. Medical degree, University of Melbourne, Australia, 1953; interne, St. Vincent's Hospital, Melbourne; residency training in pediatrics, St. Francis Hospital, Bronx, 1955-56; residency in pathalogy at St. Francis and Francis Delafield Hospital, New York City. Former adjunct pathologist, Lenox Hill Hospital, New York City, 1963-64. Member New York Academy of Science, American Association of Blood Banks, American Association for

SAMUEL SASLAW, M.D.
Columbus, O.

Chief, division of infectious diseases, Ohio State University. Project supervisor, Ohio State University Research Foundation. Ph.D., 1942, M.D., 1946, Ohio State University. Certified, American Board of Internal Medicine, 1957. Diplomate, American Board of Microbiology, 1964. Fellow, American College of Physicians. Chairman, N.I.H. Allergy and Infectious Diseases Program—project committee, 1961-65. Member Ohio State Medical Association Committee on Scientific Research. Received Alumni Award for Distinguished Teaching, Ohio State University, 1963.



GEORGE F. BOND, M.D.
Washington, D.C.



Captain, U.S. Navy Medical Corps, Washington, D.C., active duty since 1953. Qualified Diving and Submarine Medical Officer, Squadron Medical Officer, 1954-56; Officer-in-Charge, Medical Research Laboratory, 1958-64. Present duty assignment: Special Projects Office, Bureau of Naval Weapons, Man-in-the-Sea Program. Rural general practice in Bat Cave, N.C., founder and director of Valley Clinic and Hospital. University of Florida, 1939, A.B. and M.A.; McGill University School of Medicine, Montreal, 1945, M.D. and C.M. Member of AMA Council on Rural Health, 1947-57; President's Commission of the Nation's Health, 1948; President, N.C. Rural Health Committee, 1947-53; President, 10th. District, N.C. Medical Society, 1952.

Kentucky Obstetrical and Gynecological Society

Assembly Hall — Convention Center

2:00 **Color TV Program: "Pelvic Laparatomy"**
Edwin P. Solomon, M.D., Louisville, Moderator
Douglas M. Haynes, M.D., Louisville, surgeon
Harold W. Baker, M.D., Louisville
Willis E. Brown, M.D., Little Rock, Ark.
Walter M. Wolfe, M. D., Louisville

3:00 **Visit Exhibits**

3:30 **"Clinical Experience with Vesicovaginal Fistula" (with movie)**
Willis E. Brown, M.D., Little Rock, Ark.

4:10 **"Stress Incontinence"**
Arthur E. Butterfield, M.D., Lexington
Donald E. Edger, M.D., Lexington

Kentucky Society of Pathologists

Room 206 — Convention Center

2:00 **"Lipoma with Bizarre Cellular Change"**
Y. K. Im, M.D., Covington

2:20 **"The Single Unit Blood Transfusion"**
E. J. Fadell, M.D., Louisville

2:40 **"Cytologic Differentation of In Situ and Invasive Carcinoma of the Cervix in the Aged"**
Paul Gard, M.D., Lexington
Eula Jean Noble, C.T. (ASCP), Lexington
Duane Tweeddale, M.D., Lexington

3:00 **Visit Exhibits**

3:30 **"Recent Progress in Prevention and Sensitization to the RH Factor"**
John G. Gorman, M.D., New York, N.Y.

Kentucky Chapter, American Academy of Pediatrics

Room 101 — Convention Center

2:00 **"Temperature Regulation in the Newborn"**
Thomas K. Oliver, Jr., M.D., Seattle, Wash.

3:00 **Visit Exhibits**

3:30 **"Temperature Regulation in the Newborn"**
Thomas K. Oliver, Jr., M.D.
Discussion and Questions

4:00 **Business Meeting**

Kentucky Urological Society

Room 208 — Convention Center

2:00 **"Anti-ureteral Reflux Surgery"**
Chester C. Winter, M.D., Columbus, Ohio

2:30 **Movie: "Anti-ureteral Reflux Surgery"**
Chester C. Winter, M.D.

3:00 **Visit Exhibits**

3:30 **"Pyelogram Presentations"**
Members and Residents

4:25 **Business Meeting**

HOWARD H. STEEL, M.D.
Philadelphia, Pa.

Professor of orthopedic surgery, Temple University School of Medicine; associate professor of orthopedic surgery, Graduate School of Medicine, University of Pennsylvania; chief surgeon, Shriner's Hospital for Crippled Children; staff surgeon, Temple University Medical Center and St. Christopher's Hospital for children (all in Philadelphia). Former clinical professor of orthopedic surgery, University of Washington Medical School, Seattle. Medical degree, Temple, 1945; M.S., Temple, 1951. Member, American Academy of Orthopedic Surgeons, International College of Surgeons, and many others.



Doctor Steel

JOHN RANKIN, M.D.
Madison, Wisc.



Director, pulmonory research and training program, University of Wisconsin School of Medicine. Attended University of Glasgow Medical School, Scotland; received M.D. degree University of Wisconsin Medical School, 1945. Member, National Committee on Membership, American College of Chest Physicians. Fellow, American College of Chest Physicians. Member, Committee on Chest Disease, Second National Conference on Cardiovascular Disease, Washington, 1964; National Heart Institute Training Committee, U S P.H.S. Honorary Fellow, Royal College of Physicians.

EUGENE C. KLATTE, M.D.
Nashville, Tenn.

Professor and chairman, department of radiology, Vanderbilt University School of Medicine. Former associate professor of radiology, Indiana University School of Medicine. M.D., Indiana, 1952, (with high honors). Member, Association of University Radiologists, American College of Radiology, Radiological Society of North America, Society for Pediatric Radiology, Southern Radiological Conference, Middle Tennessee Radiological Society, Southern and American Medical Associations. Phi Beta Kappa, Alpha Omega Alpha.



NORMAN ALEXANDER CAMERON, M.D.
New Haven, Conn.

No Picture Available

Professor of psychiatry, Yale University. Formerly professor of psychiatry, University of Wisconsin, 1947-53; associate professor of psychiatry, Grace-New Haven Hospital, New Haven, Conn. Received M.D. from Johns Hopkins University; Ph.D. (psychology) from University of Michigan. Interned at Johns Hopkins Hospital, Baltimore, Md.; was resident at Johns Hopkins Hospital, in psychiatry. Member of American Psychol Association; G.A.P.; A.P.s.A.n.A.

WEDNESDAY, SEPTEMBER 21

MORNING SESSION

General Session

George W. Pedigo, M.D., Louisville, Vice-President (Central), Presiding

Theme—"Treatment of Infections"

9:00 **"Life on the Ocean Bottom"**
George F. Bond, M.D., Washington, D.C.

9:20 **"Hospital Acquired Infections"**
Howard H. Steel, M.D., Philadelphia, Pa.

***9:40** **"A Practical Approach to Problems in Infectious Diseases"**
Samuel Saslaw, M.D., Columbus, Ohio

10:00 **Visit Exhibits**

10:30 **Color TV Clinic: "Management of Infections"**
Mohammad Atik, M.D., Louisville, Moderator
Harold Boyer, D.D.S., Louisville
John Rankin, M.D., Madison, Wisc.
Charles Fishel, Ph.D., Louisville
Norton Waterman, M.D., Louisville

11:30 **Presentation of Scientific Exhibit Award**

PRESIDENT'S LUNCHEON

Terrace Room, Kentucky Hotel

11:50

Everett H. Baker, M.D., Louisville, KMA President, Presiding

Invocation
Rev. Mr. F. Bennett Hulse, Jr.
Beechmont Methodist Church, Louisville

Recognition
Everett H. Baker, M.D.

Rewards Presentation
William H. Bizot, M.D., Louisville, Chairman, KMA Awards Committee

"Can the Best be Better"
Walter H. Judd, M.D., Washington, D.C.

WEDNESDAY, SEPTEMBER 21

AFTERNOON SESSION

General Session

Donald K. Dudderar, M.D., Newport, Vice-President (Eastern), Presiding

Theme—"New Dimensions in Therapeutics"

2:00 **Color TV Clinic: "Drug Information and the Clinician"**
Edmund D. Pellegrino, M.D., Lexington, Moderator
David Burkholder, Pharm. D., Lexington
Harris Isbell, M.D., Lexington
Paul Parker, B.S., M.S., Lexington

**Sponsored in part by the education program of Warner-Chilcott Laboratories*

JOSEPH E. TETHER, M.D.
Indianapolis, Ind.



Assistant professor of neurology, Indiana University Medical Center, 1952 to present. Former director of clinics, assistant medical director, chief of diagnostic clinic, and associate professor of medicine, Indiana University Medical Center. M.D., Johns Hopkins, 1938. Certified, American Board of Internal Medicine, 1948. Associate, American Academy of Neurology, 1958. Fellow, American College of Physicians, 1959. Member, medical advisory board, Myasthenia Gravis Foundation, 1952 to present. Co-author of high school textbooks: Modern Health and Human Physiology.

LEON GOLDMAN, M. D.
Cincinnati, O.

Professor and chairman, Department of Dermatology, College of Medicine, University of Cincinnati. Director of Loser Laboratories, Medical Center, University of Cincinnati and the Children's Hospital Research Foundation. M.D., College of Medicine, University of Cincinnati, 1929. Director, dermatology, Cincinnati Children's Hospital and Cincinnati General Hospital. Markle Research Fellow Tropical Dermatology, 1944. Member, American Dermatological Association; Society for Investigative Dermatology, and American Academy of Dermatology.



ROBERT W. WEBER, M.D.
Salina, Kans.



Assistant clinical professor of medicine, University of Kansas; in private practice of internal medicine at Salina since 1961. Former assistant professor of medicine and microbiology, University of Kansas, 1957-61. B.S., 1947; M.D., 1949, University of Kansas; intern, University of Wisconsin; research assistant, Navy Medical research unit #4, 1950-52; resident in internal medicine, University of Kansas, 1952-55. Moderator, Infectious Disease Symposium, American Academy of General Practice, Kansas, 1956-65. Alpha Omego Alpha; fellow, American College of Physicians.

3:00 Visit Exhibits
3:30 Subject to be announced
Norman Cameron, M.D., New Haven, Conn.
3:50 "Newer Techniques in Diagnostic Radiology"
Eugene C. Klatte, M.D., Nashville, Tenn.
4:10 "Therapy in Myasthenia Gravis"
Joseph Edward Tether, M.D., Indianapolis, Ind.

THURSDAY, SEPTEMBER 22

MORNING SESSION

General Session

C. C. Lowry, M.D., Murray, Vice-President (Western), Presiding

9:00 "Some Uncommon Drug Reactions"
Leon Goldman, M.D., Cincinnati, Ohio
9:20 "Antibiotic Complications"
Robert W. Weber, M.D., Salina, Kans.
9:40 "Anticancer Agents"
George E. Moore, M.D., Buffalo, N.Y.
10:00 Visit Exhibits
10:30 Color TV Clinic: "Drugs, Their Actions and Reactions"
Randolph Scheen, M.D., Louisville, Moderator
Douglas Eastwood, M.D., Charlottesville, Va.
Robert J. McCabe, M.D., Cincinnati, Ohio
John L. Wolford, M.D., Louisville

Specialty Group Meeting

Kentucky Eye, Ear, Nose and Throat Society

Room 205 — Convention Center

9:00 "Current Concepts in the Differential Diagnosis and Treatment of Posterior Uveitis"
Robert J. Kaiser, M.D., Louisville
9:45 "Surgical Approaches to the Orbit"
Joseph A. C. Wadsworth, M.D., Durham, N.C.
10:45 Business Meeting—Election of Officers
11:15 "Eye, Ear, Nose, and Throat Aspects of Myasthenia Gravis"
Joseph E. Tether, M.D., Indianapolis, Ind.
12:30 President's Luncheon

THURSDAY, SEPTEMBER 22

AFTERNOON SESSION

Specialty Group Sessions

(There will be no General Scientific Session on Thursday afternoon. Eight Specialty Groups will meet at that time. All KMA members are cordially invited to attend any of these meetings)

Kentucky Society of Anesthesiologists

Room 101 — Convention Center

2:00 Business Meeting
3:00 Visit Exhibits
3:30 "Postoperative Respiratory Management"
Douglas Eastwood, M.D., Charlottesville, Va.

GEORGE E. MOORE, M.D.
Buffalo, N. Y.



Research professor of biology and director of Roswell Pork Division, Graduate School, State University of N.Y. at Buffalo; Clinical professor of surgery, State University of N.Y. at Buffalo. Director and chief of surgery, Roswell Pork Memorial Institute. M.D., University of Minnesota, 1947; Ph.D., University of Minnesota, 1950 (surgery). Certified, American Board of Surgery, 1952; Diplomate, American Board of Surgery. Member, Society of Experimental Biology and Medicine, the American Association of Cancer Research, American Surgical Association.

DOUGLAS W. EASTWOOD, M.D.
Charlottesville, Va.



Professor and chairman, department of anesthesiology, University of Virginia School of Medicine. M.D., 1943, M.S., 1949, both from University of Iowa. Formerly on faculty of schools of Medicine at Wayne State University, University of Iowa, and Washington University, Diplomate, American Board of Anesthesiology, 1951. Secretary, Virginia Society of Anesthesiologists, 1961-64. Member, American Association of University Profesors; American College of Anesthesiologists, American Society of Anesthesiologists, Inc., and charter member, Association of University Anesthetists.

VIRGINIA APGAR, M.D., M.P.H.
New York, N.Y.



Director, Division of Congenital Malformations Research, The National Foundation-March of Dimes. Specialist in problems of newborn infants, creator of "Apgar Score." Formerly professor of anesthesiology of Columbia University College of Physicians and Surgeons; attending anesthesiologist at the Presbyterian Hospital, N.Y., N.Y.; consultant anesthesiologist at Valley Hospital in Ridgewood, N.J.; and Goldwater Memorial and Triborough Hospitals, N.Y., N.Y. Author and lecturer, she was appointed Lecturer in Pediatrics, (Teratology), Cornell University Medical College. Member of numerous medical societies. Fellow of N.Y. Academy of Medicine and N.Y. Academy of Sciences. M.D. from Columbia University, M.P.H. from The Johns Hopkins University.

Kentucky Dermatological Society

Louisville General Hospital

2:00 Dermatology Clinic at General Hospital
3:00 Visit Exhibits
3:30 "Discussion of Clinic Cases"
Leon Goldman, M.D., Cincinnati, Ohio

Kentucky Eye, Ear, Nose, and Throat Society

Room 205 — Convention Center

1:45 "Sudden Hearing Loss, A Medical Emergency"
Francis J. Peisel, M.D., Louisville
2:15 "Microsurgical Technique for the Cataract Incision"
Herbert P. Hargett, M.D., Jeffersonville, Ind.
3:00 Visit Exhibits
3:30 "The Practical Treatment of Glaucoma"
Joseph A. C. Wadsworth, M.D., Durham, N.C.
4:30 "Rhinoplasty"
Gerald D. Landau, M.D., Louisville

Kentucky Chapter, American Academy of General Practice

Assembly Hall — Convention Center

2:00 "The Medical Management of the Surgical Patient"
Robert W. Weber, M.D., Salina, Kans.
2:20 "The Role of the Family Physician in the Control of Chronic Bronchitis and Emphysema"
William Anderson, M.D., Louisville
2:40 "Common Neurosurgical Problems in Infancy and Childhood"
Charles Wilson, M.D., Lexington

Kentucky Radiological Society

Room 203 — Convention Center

2:00 "Peripheral Venography and Diagnosis of Abnormalities of the Peripheral Venous System"
Eugene C. Klatte, M.D., Nashville, Tenn.
2:30 "Distinguishing Physical Features in Rheumatic Disorders"
David Neustadt, M.D., Louisville
2:45 "Reconstruction of Deformed Rheumatoid Hands"
Harold Kleinert, M.D., Louisville
3:00 Visit Exhibits
3:30 "Phenacetin Nephritis"
Orson Smith, M.D., Louisville
3:45 "Thoracic Arteriography"
T. R. Marshall, M.D., Louisville
4:00 "Medical Usage of Computers"
Ronald C. Kelsey, Louisville

Kentucky Psychiatric Association

Room 204 — Convention Center

To be announced

Kentucky Association of Public Health Physicians

Room 206 — Convention Center

1:30 "Early Diagnosis of Birth Defects"
Virginia Apgar, M.D., New York, N.Y.

Kentucky Chapter, American College of Surgeons

Room 104 — Convention Center

2:00 "Cell Culture of Malignant Cells"
George E. Moore, M. D., Buffalo, N.Y.
2:30 "Radical Procedures for Malignancy" (Movie)
George E. Moore, M.D., Buffalo, N.Y.
3:00 Visit Exhibits
3:30 Cancer Clinical Conference
Allan M. Lansing, M.D., Louisville

WA-AMA Pres.-Elect to Speak

Mrs. Karl Ritter, Lima, Ohio, president-elect of the Woman's Auxiliary to the American Medical Association, will address the Woman's Auxiliary to KMA at its annual meeting in Louisville, September 20-22.

Mrs. Ritter who was chosen as president-elect at the AMA auxiliary's recent meeting in Chicago, will speak on Wednesday, September 21.

Woman's Aux. Luncheon Sept. 20 To Feature Dr. Kissinger

"Busman's Holiday in Afghanistan" is the subject of an illustrated presentation to be made by Charles C. Kissinger, M.D., Henderson, at the Annual Luncheon of the Woman's Auxiliary to KMA in the Terrace Room of the Kentucky Hotel, Tuesday, September 20.

"KMA members will have an opportunity to be guests of their wives at the luncheon session," according to Mrs. Robert J. Salisbury, Mt. Sterling, president of the Woman's Auxiliary. Mrs. Salisbury urges all KMA members to be present.

Doctor Kissinger will speak on the trip he made to Afghanistan for Medico. The luncheon which will honor past presidents, members at large, and distinguished guests is scheduled for 12:30 p.m.

REGISTRATION

Please register at the Registration Booth in the north end of the Convention Hall (In the Technical Exhibit Hall) as soon as you are able. Hours are from 8:00 a.m. Tuesday, Wednesday, and Thursday, September 20, 21, and 22.

You are requested to wear your badges at all times while attending the meeting.

Sept. 19 Orientation Course Set For New KMA Members

Over 120 new KMA members will have an opportunity to take the third KMA Orientation Course, which will be held at the Kentucky Hotel, Monday, September 19, during the 1966 Annual Meeting.

Many hours of preparation by the Orientation Committee have produced an outstanding program, designed to better equip the new KMA member in meeting present-day responsibilities as a citizen and as a physician. The fast-moving session will begin promptly at 8:30 a.m. and will adjourn following the luncheon program.

Letters of invitation have been sent to those members who have joined the association since the beginning of the 1965 associational year and who have not yet attended an Orientation Course. Following is the program to be presented at the third Orientation Course on Monday, September 19.

KMA Orientation Course

Kentucky Hotel

September 19, 1966

Moderator

N. Lewis Bosworth, M.D., Lexington, Chairman

8:00 a.m. Registration

8:30 a.m. Welcome and Introduction
Everett H. Baker, M.D., Louisville
KMA President

8:35 a.m. Structure-Function-Policies of Organized Medicine
Andrew M. Moore, M.D., Lexington,
Past President
Fayette County Medical Society
Kentucky Medical Association
Henry B. Asman, M.D., Louisville,
KMA Secretary
American Medical Association
Robert C. Long, M.D., Louisville, Member AMA Board of Trustees

9:20 a.m. "Community Relations"
Charles Rutledge, M.D., Hazard, Alternate Delegate to AMA

9:40 a.m. "Health Insurance"
(Blue Cross-Blue Shield)
J. Ed McConnell, Louisville, Vice-President, Blue Cross-Blue Shield

9:55 a.m. "Health Insurance"
(Commercial)
George M. Paterson, Louisville, District Group Claims Manager, New York Life Insurance Company

10:10 a.m. Coffee Break

10:25 a.m. "Medical Ethics"
Clyde C. Sparks, M.D., Ashland, KMA Past President

10:45 a.m. "Medico-Legal Aspects"
E. Gaines Davis, Jr., Frankfort, KMA Legal Counsel

11:05 a.m. "Medico-Press Relations"
William Gladden, Louisville, Director of Public Relations, WAVE, Inc.

11:20 a.m. "The National Scene for Medical Legislation"
John C. Quertermous, M.D., Murray, Chairman for National Affairs, KMA Council on Legislative Activities

11:35 a.m. "State Legislation and the KMA Key Man System"
J. C. Cantrill, M.D. Georgetown, Chairman for State Affairs, KMA Council on Legislative Activities

11:45 a.m. "The Physicians Role in Legislation and Politics"
Hoyt D. Gardner, M.D., Louisville, President Jefferson County Medical Society

12:15 a.m. Luncheon (with wives)
"The Wife's Role in Organized Medicine"
Mrs. Robert J. Salisbury, Mt. Sterling, President, Woman's Auxiliary to KMA

Plan Special Med. School Tours for U of L Alumni

Special "hospitality" tours of the University of Louisville Medical School will be a new addition to the traditional medical school alumni reunions held during the 1966 KMA Annual Meeting.

The special tours are scheduled for Tuesday, September 20 from 4 to 6 p.m. Other reunion plans were incomplete at press time.

Eleven five-year classes will hold reunions this year. The class of 1916 is celebrating its 50th anniversary and the class of 1941 its 25th.

For additional information on individual reunion parties scheduled for your class, contact your chairman listed below. If no chairman is listed for your class, contact Les Shively, U of L director of alumni relations.

1911—Oscar O. Miller, M.D., Louisville
1916—To be announced
1921—To be announced
1926—K. Armand Fischer, M.D., Louisville
1931—William K. Keller, M.D., Louisville
1936—George F. McAuliffe, M.D., Louisville
1941—Frederick Ehrman, M.D., Louisville
1946—March—to be announced
July—Alan Willner, M.D., Clarksville, Ind.
1951—Lyle Havens, M.D., Jeffersonville, Ind.
1956—David C. Shipp, M.D., Louisville
1961—To be announced

Reserve Your Hotel Space Now

If you have not yet made your hotel reservations for the KMA Annual Meeting on September 20-22, you are urged to do so as soon as possible by KMA President Everett H. Baker, M.D., Louisville.

Hotels and motels in downtown Louisville or within easy access of the convention facilities offer excellent accommodations. In order to be sure of rooms, it is suggested that you make your reservations now.

Color TV Clinics to Highlight 1966 Scientific Program

Five closed circuit color TV clinics will highlight the general sessions at the KMA Annual Meeting in Louisville's Convention Center on September 20-22, according to Roderick Macdonald, M.D., Louisville, chairman of the program committee.

Closed circuit TV will also be used in the specialty group meeting of the Kentucky Obstetrical and Gynecological Society on Tuesday afternoon.

Television panel participants will incude both national and local speakers. The television programs will originate at the University of Louisville Medical Center through the auspices of Smith Kline & French Laboratories.

First color television seminar will be on "Modern Concepts in Pathogenesis, Presentation, and Treatment of Erythroblastosis Fetalis" at 10:50 on Tuesday morning, September 20. The Ob-Gyn group will have a TV program on "Pelvic Laparotomy" at 2 on Tuesday afternoon.

"Management of Infections" will be the subject of a color TV clinic on Wednesday morning at 10:30. That afternoon at 2 p.m., the TV subject will be "Drug Information and the Clinician".

The final general session Thursday morning at 10:30 will feature a TV panel on "Drugs, Their Actions and Reactions".

Number to Call is 584-2201 In Case of Emergency

If you wish to be contacted while attending the KMA Annual Meeting in Louisville, you should leave the number 584-2201 (Area Code 502) with your home, office or hospital.

The Message Center, located in the middle of the Technical Exhibit Hall at the Convention Center, is an efficient and convenient center for the transfer of messages.

Individual physicians will not be paged. This is due to the arrangement of facilities for the meetings.

Only emergency calls will be posted on the blackboards in the entrance lobby of the Convention Center and the Scientific Assembly Hall. *All messages* will be on file and may be picked up at the message center. You are asked to check there frequently for your calls.

If you wish to locate other physicians you may do so through the message center. Just call 584-2201 and ask that your message be delivered.

Phone number at the Kentucky Hotel is 587-1181. If you are attending the meetings of the House of Delegates on Monday, September 19 (beginning at 9 a.m.) or Wednesday evening, September 21 (starting at 6:30) your calls should be directed to the Terrace Room.

"In order to receive all calls and messages quickly, all physicians are urged to make use of the message center," said Everett H. Baker, M.D., Louisville, KMA president. Trained employees of Southern Bell will staff the center.



Senator Fannin



Senator Inouye

Sen. Fannin, Inouye to Speak at Annual KEMPAC Seminar

Senators Paul J. Fannin (R.—Ariz.) and Daniel K. Inouye (D.—Hawaii) will be featured speakers at the fourth annual seminar of the Kentucky Educational Medical Political Action Committee (KEMPAC) on Monday evening, September 19, at the Kentucky Hotel.

"Future Legislative National Programs Relating to Medicine" is the topic of this year's seminar. A reception in the Flag Room at 6 p.m. will precede a dinner at 7 p.m., according to an announcement from Richard F. Greathouse, M.D., Louisville, secretary of the KEMPAC Board of Directors. The seminar will follow the dinner.

George J. Lawrence, Jr., M.D., Flushing, N.Y., will represent AMPAC at the seminar. He is former secretary-treasurer of AMPAC and a member of its Board of Directors.

Republican Senator Fannin, a member of the Senate Interior and Insular Affairs Committee and the Senate Labor and Public Welfare Committee, was elected to the U.S. Senate in 1964. A native of Ashland, Ky., he graduated from Stanford University in 1930. A former Governor of Arizona, he served three terms on the executive committee of the National Governors' Conference. He was a member of the President's Civil Defense Advisory Council in 1963-4. In 1963, he was chairman of the Western Governors' Conference.

Democratic Senator Inouye, who was the first American of Japanese ancestry in Congress, was elected to the Senate in 1962 at the age of 38 after serving two terms as Hawaii's first Representative. Born in Honolulu, Inouye served in Italy and France during World War II and lost his right arm in battle. He started as a private and ended up as a captain, winning the Distinguished Service Cross and the Bronze Star. A law school graduate of George Washington University, he is chairman of the speakers bureau of the Democratic Senatorial Campaign Committee and is on the Armed Services and the Public Works committees.

KMA Annual Meeting to Honor 1886 President, J.P. Thomas

The 1966 Kentucky Medical Association Annual Meeting will be officially titled the Joseph Potts Thomas Memorial Meeting in remembrance of the 1886 president of the Association.



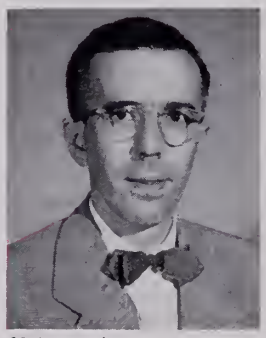
The tradition of honoring a past president of KMA or some distinguished physician each year at the Annual Meeting was started in 1935.

KMA Historian, Eugene H. Conner, M.D., Louisville, has written an interesting biography of Doctor Thomas for the program booklet, which will be distributed at the Annual Meeting in Louisville, September 20, 21, and 22.

KMA Official Historian

Eugene H. Connor, M.D., Louisville

Named KMA historian in April, 1964, to replace the late Emmet Field Horine, M.D., Brooks, Doctor Connor is also Book Review Editor of *The Journal*. A graduate of the University of Maryland School of Medicine in 1945, he is professor of anesthesiology and head of the anesthesiology department at the University of Louisville School of Medicine. Doctor Connor was special editor of the 60th anniversary historical edition of *The Journal* published in November, 1963. He is currently editor of the *Bulletin* of the Jefferson County Medical Society. Before coming to Louisville he was director of anesthesiology at Philadelphia General Hospital and assistant professor of anesthesiology at the University of Pennsylvania.



KMA to Give Three Top Awards at President's Luncheon

Presentation of KMA's three top awards will be a feature of the 1966 President's Luncheon on Wednesday noon, September 21, in the Kentucky Hotel's Terrace Room, according to William H. Bizot, M.D., Louisville, Awards Committee chairman.

The three annual awards are the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award. In 1965, J. Duffy Hancock, M.D., Louisville, received the Distinguished Service Award and W. Gerald Edds, M.D., Calhoun, was given the Outstanding GP Award. Mrs. James S. Frankel, Lexington, was awarded the R. Haynes Barr Award for outstanding service by a layman in the field of public health.

The Awards Committee will present its nominations for the first two awards to the House of Delegates at its first session on Monday, September 19. Other nominations may be made from the floor. The recipient of the Barr award is made by the Awards Committee.

Those serving with Doctor Bizot on the Awards Committee are: Richard Grise, M.D., Bowling Green; James M. Keeton, M.D., Ashland; Joseph Keith, Jr., M.D., Lexington; and Max D. Klein, M.D., Shelbyville.

1966-67 Officers to be Elected At Final House Session

Officers of KMA for 1966-67 will be elected at the final session of the House of Delegates on Wednsday evening, September 21. Officers to be chosen at that time are:

President-Elect	**(Western)**	**One Year**
Vice-Presidents	**(Central)**	**One Year**
	(Eastern)	**One Year**
	(Western)	**One Year**

***Secretary: three years. (incumbent, Henry B. Asman, M.D., Louisville)**

***Treasurer: three years. (incumbent, Keith P. Smith, M.D., Corbin)**

***AMA Delegates: for term-Jan. 1, 1967 to Dec. 31, 1968 (incumbent J. Thomas Giannini, M.D., Louisville)**

***AMA Alternate Delegate: for term—Jan. 1, 1967 to Dec. 31, 1968 (incumbent, Charles G. Bryant, M.D., Louisville)**

Five new trustees will be elected for regular three-year terms and one will be elected to fill the unexpired term of the late James W. Archer, M.D., Paintsville, in the Fourteenth District. A list of districts which will elect trustees follows.

***Fifth District (incumbent, A. O. Miller, M.D., Louisville)**

***Sixth District (incumbent, Rex E. Hayes, M.D., Glasgow)**

***Eighth District (incumbent, W. Donald Janney, M.D., Covington)**

Eleventh District (incumbent, Hubert C. Jones, M.D., Berea)

Fourteenth District (to fill unexpired term ending 1968)

***Fifteenth District (incumbent, E. C. Seeley, M.D., London)**

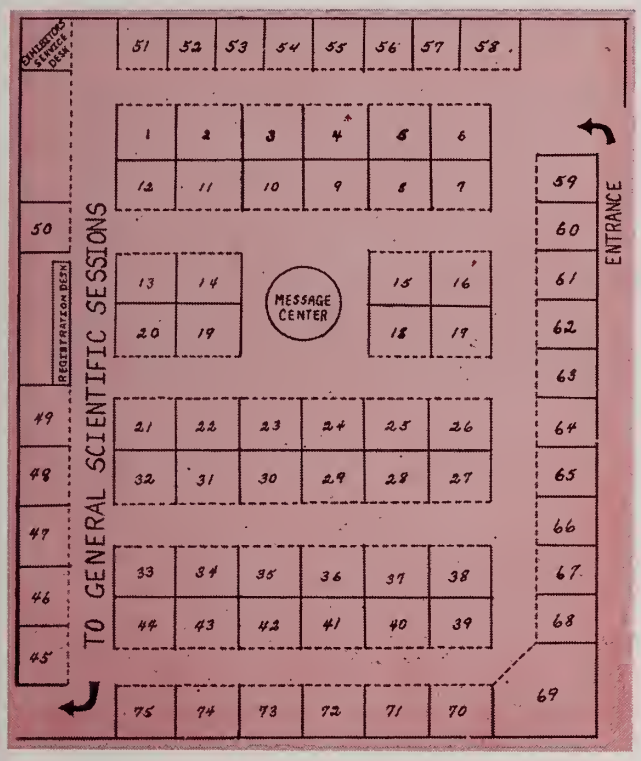
Doctor Jones has served two full terms and therefore may not succeed himself. Doctor Seeley completed the unexpired term of R. E. Pennington, M.D., who was made president-elect in 1965 and he is eligible for re-election.

**All are eligible for re-election*

Please Take This Issue Home

The special features presented in this issue of The Journal may be of interest to your wife. In addition to the program of her own meeting of The Woman's Auxiliary to KMA, she will enjoy reading of the activities planned for the regular KMA Annual Meeting. KMA President Everett H. Baker, M.D. urges that you carry this issue home to your wife for her information and enjoyment.

Opportunity to Keep Up with Research Advances Offered by 1966 Technical Exhibits



The 75 technical exhibits at your Annual Meeting offer you an unparalleled opportunity to keep up with expanding research in pharmaceuticals and the newest developments in medical instruments, equipment, literature, and services. Their graphic presentations condense an encyclopedia of ideas and give you a chance to weigh the merits of services and products bearing a close and ethical relationship to your practice.

In the care and treatment of your patient, you and the ethical drug manufacturers share a mutual responsibility in which the exchange of information is essential. Both you and your patients should benefit from the increased knowledge you will gain from a visit to the technical exhibits.

A 30-minute intermission has been planned for each morning and afternoon general scientific session and during the specialty group meetings so that every physician will have time to visit the exhibits.

TECHNICAL EXHIBITORS

Abbott Laboratories (20)
Ames Company (60)
Arnar-Stone Laboratories, Inc. (51)
Ayerst Laboratories (12)

Blaine Company (73)
Blue Cross-Blue Shield (25)
Borcherdt Company (21)
Borden Company, Pharmaceutical Division (39)
Bristol Laboratories (34)
Burroughs Wellcome & Co. (U.S.A.), Inc. (43)
Burton, Parsons & Company, Inc. (75)

Carnation Company (36)
Central Dairy Council (66)
Ciba Pharmaceutical Company (22)
Coca-Cola Company, The (69)
Crocker-Fels Company, The (70)

Dictaphone Corporation (31)
Dome Chemicals (64)
Dorsey Laboratories (62)
Eaton Laboratories (50)
Encyclopaedia Britannica, Inc. (61)
Flint Laboratories (5)

Geigy Pharmaceuticals (58)
Gerber Products Company (74)
Guild of Prescription Opticians of Kentucky (8)

Hancock, John (68)
Hewlett-Parkard/Crossley Sales Division (4)

Kay Surgical, Inc. (33)
Kentucky Pepsi-Cola Bottlers Association (54)

Lederle Laboratories (14)
Lee, A. P. Agency (72)
Lilly, Eli and Company (19)
Lippincott, J. B. Company (11)

Majors, J. A. Company (17)
Malkin Instrument Company (67)
McNeil Laboratories, Inc. (10)
Mead Johnson Laboratories (26)
Medco and Siemens (2)
Medical Protective Company, The (63)
Merck Sharp & Dohme (7)
Merrill Lynch, Pierce, Fenner & Smith, Inc. (52)
Meyer Laboratories (65)
Mosby, C. V. Company, The (27)
Mutual Benefit Life Insurance of Newark, New Jersey (35)

Ortho Pharmaceutical Corporation (32)

Parke, Davis & Company (15)
Pfizer Laboratories (44)
Poythress, William P. & Co., Inc. (55)

Ransdell Surgical, The (56)
Reynolds, R. J. Tobacco Company (29)
Richards Manufacturing Company (53)
Robins, A. H. Company, Inc. (57)
Roche Laboratories (13)
Roerig, J. B. & Company (1)
Ross Laboratories (49)

Sandoz Pharmaceuticals (9)
Schering Corporation (23)
Searle, G. D. & Co. (16)
Sherman Laboratories (30)
Smith Kline & French Laboratories (6)
Smith, Miller & Patch, Inc. (59)
Snell's Artificial Limb & Brace Company (41)
Squibb, E. R. & Sons (45)
Stuart Company, The (Division of Atlas Chemical Industries, Inc.) (28)
Syntex Laboratories, Inc. (71)

Tafel Surgical Supply Co., Inc. (37)
3M Business Products Sales, Inc. (48)

United States Tobacco Company (3)
U.S. Vitamin & Pharmaceutical Corp. (42)
Upjohn Company (47)

Wallace Laboratories (38)
Warren-Teed Pharmaceuticals (46)
Westwood Pharmaceuticals (40)
Winthrop Laboratories (18)
Wocher, Max & Son Company, The (24)



LOUISVILLE COUNTRY CLUB'S beautiful 18-hole golf course on Upper River Road in Louisville will be the location of this year's KMGA golf tournament, to be held Monday, September 19. The tournament is held annually in conjunction with the KMA Annual Meeting.

Louisville Country Club to Host 1966 KMA Golf Tournament Sept. 19

Arrangements have been made to hold the 1966 Kentucky Medical Association Golf Tournament at the Louisville Country Club on Upper River Road on September 19. The extensive rebuilding of the fairways at this beautiful club, which necessitated the cancellation of plans for last year, has been very satisfactory, and the course should be in fine condition.

The tournament, an annual event, is being held again this year in conjunction with the KMA Annual Meeting in Louisville. The country club will be open that day to KMA members entering the tournament, according to James Douglas, M.D., Louisville, chairman of the KMA Golf Committee.

All participants will tee off between 10:00 a.m. and 2:00 p.m. KMA members desiring to play in this year's tournament must submit their dues and application forms prior to the registration deadline of Thursday, September 1. (*See application form below.*)

Locker room attendants, pro-shop attendants, and caddies will be made available by the club. A limited number of golf carts will be available.

Permanent trophies will be given to low net and low gross winners in the championship and senior divisions. Other prizes will be presented. The Calloway handicap scoring system will be used. Participants need not submit handicaps.

APPLICATION FOR MEMBERSHIP

KMA Golf Association

Please complete and return immediately to: KMA Golf Committee
Kentucky Medical Association
3532 Janet Avenue, Louisville, Kentucky 40205

Name .....

Address ..... (Town) .....

Amount enclosed: .....$7 (Regular playing member) .....$4 (non-playing member)

....$4 (I am a member of Louisville Country Club) Others I would like to play with are:.....

.....I would like to tee off at the following time .....

TOURNAMENT WILL BE HELD MONDAY, SEPTEMBER 19.

PROGRAM
FORTY-FOURTH ANNUAL CONVENTION
Of The
WOMAN'S AUXILIARY
To The
KENTUCKY MEDICAL ASSOCIATION

SEPTEMBER 20-21-22

1966

KENTUCKY HOTEL **LOUISVILLE, KENTUCKY**

REGISTRATION

Lobby, Kentucky Hotel

Monday	12 Noon - 5:00 PM
Tuesday	7:30 AM - 5 PM
Wednesday	9:00 AM - 11:00 AM

(all times are Eastern Standard)

PRE-CONVENTION LEGISLATIVE WORKSHOP

MONDAY, SEPTEMBER 19th-2PM-4PM

Mrs. Harry Fry and Mrs. George Griffin, Cincinnati, conductors, assisted by Mrs. A. S. Holmes, Legislative Chairman. This workshop is sponsored by KEMPAC and will be held in Room 1510.

TUESDAY, SEPTEMBER 20

8:00 AM

Pre-convention Board Breakfast (subscription): Parlor B, Kentucky Hotel. All general officers, chairmen of standing and special committees, three past presidents, councilors, co-ordinator for members-at-large, and the county presidents are urged to attend.

Continental Breakfast:
Room 312, 8 AM-10 AM

10:00 AM
MIRROR ROOM

Formal opening of the 44th Annual Convention of the Woman's Auxiliary to the Kentucky Medical Association.

Mrs. Robert J. Salisbury, President, presiding

Invocation ..... Mrs. Paul E. Lett, Lancaster, Chaplain

Pledge of Allegiance to the Flag
Mrs. Mark Judge, Central City

Pledge of Loyalty ..... Mrs. J. Murray Kinsman, Louisville, National Director, Auxiliary to the AMA

Address of Welcome ..... Mrs. S. Randolph Scheen, President, Jefferson County

Presentation of Distinguished Guests
Mrs. Robert J. Salisbury, Mt. Sterling

In Memoriam ..... Mrs. Paul E. Lett, Lancaster, Chaplain

Adoption of Convention Rules
Mrs. Earl W. Roles, Louisville, Parliamentarian

Announcements ..... Mrs. Hugh P. Adkins, Convention Chairman

Roll Call of Delegates . Mrs. James A. Harris, Paducah, Recording Secretary

Minutes of the 43rd Annual Meeting
Mrs. James A. Harris

Report of the 1966 National Convention
Mrs. Guy Morford, Owensboro, Past President

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association
Mrs. Harold B. Barton, Corbin

Greetings ..... Mrs. Shelley Bennet, President WA-SAMA, University of Kentucky

Greetings ..... Mrs. Theodore Buckner, President, WA-SAMA, University of Louisville

President's Report ..... Mrs. Robert J. Salisbury

Reports of Officers

President-Elect and Membership Chairman
Mrs. Raymond E. Jones, Louisville

Vice Presidents . Mrs. Ballard W. Cassady, Pikeville
Mrs. Charles C. Kissinger, Henderson
Mrs. O. L. May, Danville

Treasurer .... Mrs. William C. Durham, Louisville

Corresponding Secretary .... Mrs. Joseph Keith, Jr., Lexington

Reports of Councilors

Reports of Chairman

Unfinished Business

New Business

Resolution from the Board of Directors

Report of the Nominating Committee
Mrs. J. Jack Martin, Tompkinsville, Chairman

Presentation of the 1966-67 Budget
Mrs. J. Murray Kinsman, Louisville, Finance Chairman

Election of the 1966-67 Nominating Committee

Presentation of Legislation Appreciation Award
Mrs. A. S. Holmes, Corbin, Legislation Chairman

Presentation of "Helping Hands" Award
Mrs. Everett O. Blair, Morehead, Rural Health Chairman

Report of Registration ..... Mrs. Morgan R. Colbert, Louisville

LUNCHEON
12:30 PM
TERRACE ROOM
Honoring

Past Presidents, Member-at-Large, and Distinguished Guests

Invocation .....Mrs. Wendell R. Kingsolver, Carlisle
Presentation of Membership Awards
Mrs. Raymond E. Jones, Louisville
"Busman's Holiday in Afganistan"
Dr. and Mrs. Charles C. Kissinger, Henderson
Introduction by Mrs. Daryl P. Harvey, Glasgow, Chairman, Program Committee

2:00 PM
MIRROR ROOM

Reports of County Auxiliary Presidents
Vice Presidents presiding:
Mrs. Ballard W. Cassady
Mrs. Charles C. Kissinger
Mrs. O. L. May

Barren-Metcalf, Bell, Boyd-Carter-Greenup, Boyle, Bourbon, Calloway, Christian, Daviess, Fayette, Franklin, Fulton, Hardin-Larue, Harlan, Henderson, Hopkins, Jefferson, Johnson-Floyd-Magoffin, Laural Madison, Marion-Washington, Mason, McCracken, Montgomery-Bath-Menifee, Muhlenburg, Perry-Knott, Pike, Pulaski, Rowan, Taylor-Green, Warren, Whitley

WEDNESDAY, SEPTEMBER 21

9:15 AM
MIRROR ROOM

Invocation ..... Mrs. J. O. Stein, Somerset
Roll Call ..... Mrs. James A. Harris
Reading of the Minutes ..... Mrs. James A. Harris
Presentation of Distinguished Guests
Announcements ..... Mrs. Hugh P. Adkins
Presentation of Community Service Award
Mrs. Robert J. Salisbury
Address ..... Mrs. Karl Ritter, Lima, Ohio, President-Elect Woman's Auxiliary to the AMA
Election of Officers
Installation of Officers ..... Mrs. Karl Ritter
Presentation of Gavel and Pin .Mrs. Robert J. Salisbury
Inaugural Address .....
Mrs. Raymond E. Jones
Announcement of Committee Chairmen
Mrs. Raymond E. Jones
Presentation of Past President's Pin . Mrs. Earl W. Roles
Address ..... Everett H. Baker, M.D., President of KMA
Final report of Registration ..Mrs. Morgan R. Colbert
Courtesy Resolutions .. Mrs. David M. Cox, Louisville

LUNCHEON AND STYLE-SHOW
12:30 PM
FLAG ROOM
Honoring

Mrs. Karl Ritter, President-Elect
Woman's Auxiliary to the American Medical Association
Invocation ..... Mrs. James L. Ferrell, Paris
Presentation of Distinguished Guests
Presentations of Officers
Fashion Show

THURSDAY, SEPTEMBER 22

8:45 AM
PARLOR A
Post-Convention Board Breakfast

Presiding ..... Mrs. Raymond E. Jones
Invocation ..... Mrs. Morgan R. Colbert
Meeting of Membership Committee

RULES OF THE CONVENTION

1. Badges must be worn by the voting body during all general sessions.
2. Delegates' privileges are transferable only with the knowledge and approval of the Credentials Committee.
3. Officers and delegates are requested to sit in the sections assigned to them. All persons appearing on the program are requested to sit near the front.
4. When addressing the Chair, a speaker shall announce her name and the name of her county auxiliary.
5. Each speaker from the floor shall be limited to *two* minutes. No one shall speak more than twice on the same question.
6. Officers giving reports shall be limited to *three* minutes.
7. County presidents giving reports shall be limited to *two* minutes unless more time is specified by the president.
8. A time keeper shall notify each speaker when the allotted time has expired.
9. Only a voting member shall offer motions and vote. Motions must be in writing, signed by the mover, and presented to the recording secretary, when so requested by the Chair.
10. No announcements shall be made from the floor. All announcements of a vital nature shall be made from the platform with the consent of the president after they have been submitted in writing to her.
11. The right to the floor may be granted to non-delegate members by consent of the Chair or by majority vote of the delegates.
12. Visitors are welcome to all general sessions. All visitors and auxiliary members are requested to register.

Pledge of Loyalty

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

1966 STATE CONVENTION COMMITTEES

General Chairman ... Mrs. Hugh P. Adkins, Louisville
Co-Chairman ..... Mrs. Edgar B. Morgan, Louisville
Registration ..... Mrs. Morgan R. Colbert, Louisville
Decorations ..... Mrs. Charles G. Bryant, Louisville
Finance .....Mrs. William C. Durham, Louisville
Tuesday Luncheon Mrs. George W. Schafer, Louisville
Wednesday Luncheon
Mrs. Edgar B. Morgan, Louisville

Tickets ..... Mrs. Samuel M. Smith, Jr., Louisville
Mrs. William R. Moore, Louisville
Fashion Show ..... Mrs. Rudy J. Ellis, Louisville
Publicity ..... Mrs. Carroll L. Witten, Louisville
Hobby Show ..... Mrs. Robert B. Nolan, Louisville
Mrs. Max P. Jones, Pikeville
Gift Drawing .... Mrs. H. Bernard Asman, Louisville
Exhibits ..... Mrs. Gordon L. Smiley, Louisville
Tellers ..... Mrs. C. Nicholas Kavanaugh, Lexington
Mrs. Lundy Adams, Blackey
Mrs. William Hornaday, Owensboro
Pages ..... Mrs. Don C. McFadden, Mt. Sterling
Mrs. James B. Cox, Hopkinsville
Mrs. Joseph R. Miller, Benton
Timekeepers ..... Mrs. Phillip VanDeventer, Hopkinsville
Mrs. Graydon A. Long, Lexington

STATE OFFICERS

President ..... Mrs. Robert J. Salisbury, Mt. Sterling
President-Elect ... Mrs. Raymond E. Jones, Louisville
First Vice-President .Mrs. Ballard W. Cassady, Pikeville
Second Vice-President ..... Mrs. Charles C. Kissinger, Henderson
Third Vice-President ..... Mrs. O. L. May, Danville
Fourth Vice-President ..... Mrs. Robert A. Stewart, Ashland
Recording Secretary .... Mrs. James A. Harris, Paducah
Treasurer ..... Mrs. William C. Durham, Louisville
Corresponding Secretary ..... Mrs. Joseph Keith, Jr., Lexington
Parliamentarian ..... Mrs. Earl W. Roles, Louisville

ADVISORY COMMITTEE

J. Andrew Bowen, M.D., Louisville
Jesse T. Funk, M.D., Bowling Green
Coleman C. Johnston, M.D., Lexington

IMMEDIATE PAST PRESIDENTS

Mrs. James Sears Rich, Lexington
Mrs. J. Murray Kinsman, Louisville
Mrs. J. Jack Martin, Tompkinsville

DISTRICT COUNCILORS

1st—Mrs. Joseph R. Miller, Benton
2nd—Mrs. John A. Logan, III, Sebree
3rd—Mrs. Jere C. Robertson, Hopkinsville
4th—Mrs. Forest F. Shely, Campbellsville
5th—Mrs. Carlisle, Morse, Louisville
6th—Mrs. Oris Aaron, Columbia
7th—Mrs. Hugh C. Williams, Carrollton
8th—Mrs. John R. Stevie, Covington
9th—Mrs. J. E. McKenney, Maysville
10th—Mrs. J. S. Williams, Nicholasville
11th—Mrs. Harold S. Moberly, Jr., Winchester
12th—Mrs. Charles E. Peck, Russell Springs
13th—Mrs. A. B. Richards, Louisa
14th—Mrs. Lloyd M. Hall, Salyersville
15th—Mrs. T. R. Davies, Bourbourville
Co-Ordinator for Members-at-Large, Mrs. Hugh C. Smith, Georgetown

COMMITTEE CHAIRMEN

American Medical Association-Education & Research Foundation ..... Mrs. Robert C. Long, Louisville
Benevolence ..... Mrs. John M. Baird, Danville
Blue Grass News, Editor
Mrs. U. Ray Ulferts, Louisville
Co-Editor ..... Mrs. Victor P. Dalo, Louisville
By-Laws ..... Mrs. Earl W. Roles, Louisville
Chaplain ..... Mrs. Paul E. Lett, Lancaster
Community Service ..... Mrs. William H. McBeath, Lexington
Convention ..... Mrs. Hugh P. Adkins, Louisville
Co-Chairman ... Mrs. Edgar B. Morgan, Louisville
Disaster Preparedness ... Mrs. Richard J. Wever, Paris
Doctor's Shop ..... Mrs. Bacon R. Moore, III, Harrodsburg
Finance ..... Mrs. J. Murray Kinsman, Louisville
Health Careers ..... Mrs. H. D. Gardner, Louisville
Co-Chairman ..... Mrs. Harold B. Barton, Corbin
Historian ..... Mrs. David M. Cox, Louisville
International Health Activities ... Mrs. James S. Rich, Lexington
Legislation ..... Mrs. A. S. Holmes, Corbin
Co-Chairman ..... Mrs. K. B. Daniel, Danville
McDowell House .... Mrs. H. Walker Owens, Danville
Membership ..... Mrs. Raymond E. Jones, Louisville
Mental Health .... Mrs. R. Haynes Barr, Owensboro
Nominations ..... Mrs. J. Jack Martin, Tompkinsville
Past Presidents ... Mrs. J. Jack Martin, Tompkinsville
Program ..... Mrs. Daryl P. Harvey, Glasgow
Publicity ..... Mrs. Carroll L. Witten, Louisville
Reports ..... Mrs. Charles F. Blankenship, Louisville
Rural Health ..... Mrs. Everett D. Blair, Morehead
Safety ..... Mrs. Harry J. Cowherd, Frankfort
WA-SAMA-WA-KMA Liaison
Lexington ..... Mrs. Ben W. Crawford, Lexington
Louisville ..... Mrs. S. Randolph Scheen, Louisville

PAST PRESIDENTS

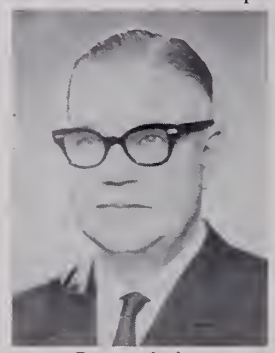
*1923—Mrs. Graham Lawrence, Shelbyville
*1924—Mrs. Graham Lawrence, Shelbyville
*1925—Mrs. Van Albert Stilley, Benton
*1926—Mrs. Van Albert Stilley, Benton
*1927—Mrs. William M. Martin, Harlan
*1928—Mrs. James Thomas Reddick, Paducah
1929—Mrs. P. E. Blackerby, Louisville
1930—Mrs. E. B. Houston, Murray
*1931—Mrs. George A. Hendon, Louisville
1932—Mrs. Arthur T. McCormack, Louisville
*1933—Mrs. Bartlett K. Menefee, Covington
*1934—Mrs. Joseph L. Greenwell, New Haven
1935—Mrs. Luther Bach, Florence
*1936—Mrs. Ernest Arthur Barnes, Albany
*1937—Mrs. Stephen C. McCoy, Louisville
*1938—Mrs. Harlan Usher, Sedalia
1939—Mrs. Reasor T. Layman, Elizabethtown
1940—Mrs. John M. Blades, Butler
*1941—Mrs. John G. South, Frankfort
1942—Mrs. John B. Floyd, Richmond
1943—Mrs. Octavus Dulane, Louisville
*1944—Mrs. Eleanor Hume Offutt, Frankfort
1945—Mrs. Shelby Carr, Richmond
1946—Mrs. Elmer L. Henderson, Louisville
1947—Mrs. Walker Owens, Danville
1948—Mrs. R. Haynes Barr, Owensboro
1949—Mrs. Elbert W. Jackson, Paducah
1950—Mrs. Clark Bailey, Harlan
1951—Mrs. John S. Harter, Louisville
1952—Mrs. David Woolfolk Barrow, Lexington
1953—Mrs. Clyde C. Sparks, Ashland
1954—Mrs. Karl D. Winter, Louisville
1955—Mrs. R. Ward Bushart, Fulton
1956—Mrs. Charles B. Stacy, Pineville
1957—Mrs. J. Andrew Bowen, Louisville
1958—Mrs. Jesse T. Funk, Bowling Green
1959—Mrs. Charles B. Johnson, Russell
1960—Mrs. Earl W. Roles, Louisville
1961—Mrs. Guy Morford, Owensboro
1962—Mrs. James Sears Rich, Lexington
1963—Mrs. J. Murray Kinsman, Louisville
1964—Mrs. J. Jack Martin, Tompkinsville

**Deceased*

ORGANIZATION SECTION

14th Dist. Trustee Dr. Archer Passed Away June 28

James W. Archer, M.D., Paintsville, who was elected a trustee representing KMA's Fourteenth District at the 1965 Annual Meeting, died suddenly on June 28 after becoming ill while on duty at Paintsville Hospital.



Doctor Archer

A graduate of the University of Louisville School in 1939, he had been engaged in private practice in Paintsville since 1940 when he completed his internship at St. Anthony's Hospital, Oklahoma City, Okla.

Doctor Archer has served the KMA in numerous capacities and has also been active in the KAGP. He had been chairman of the KMA Nominating Committee, a legislative key man, and for 13 years was a delegate to KMA. A past president of the Johnson County Medical Society, he served on the Paintsville City School Board of 14 years and was a past president of the Painstville Rotary Club.

His survivors include his wife, two children, and a brother George P. Archer, M.D., Prestonsburg, past president of KMA.

KMA Board of Trustees Reviews Ky. Medical Assistance Program

A special called meeting of the KMA Board of Trustees was held on July 6 to review recommendations for expansion and revision of benefits of the Kentucky Medical Assistance Program as had been approved by the Governor's Advisory Council on Medical Assistance.

The three recommendations approved by the Board according to Everett H. Baker, M.D., KMA President, who requested the called meeting, were:

1. To endorse the concept of compensation of all physicians on the basis of their usual, customary and reasonable fee and strongly recommends that this be applied in the implementation of all medical care programs under PL 89-97.
2. To recommend that the proposal to expand the public assistance program and similar programs be administered financially and otherwise through the Department of Health.
3. To offer the services of the KMA Insurance Review Board to the Department of Health to review specific cases recognizing there would be a minimal number of disagreements between the Department and the individual physician in the administering of the expanded medical assistance program.

The above recommendations were presented to the Governor's Advisory Council on Medical Assistance at a meeting on Monday, July 11, but were not adopted by the Council. It was indicated that the Council would make a further study of these proposals.



Doctor Rouse



Doctor Hudson

Dr. Rouse Named AMA Pres.-Elect; Dr. Hudson is New President

Milford O. Rouse, M.D., Dallas, was elected by the House of Delegates as president-elect of the American Medical Association at the annual meeting, in Chicago, June 26-30. Doctor Rouse formerly served as Speaker of the AMA's House of Delegates since 1963, after having been vice-speaker for four years previously.

Charles L. Hudson, M.D., internist from Cleveland was installed June 28 as the 121st. President of the AMA. Before his election to the office, Doctor Hudson had been a member of the AMA Board of Trustees since 1961. He is a past president of both the Academy of Medicine of Cleveland and the Ohio State Medical Association.

Doctor Rouse, a clinical professor of medicine (gastroenterology) at the University of Texas Southwestern Medical School, is past-president of the Southern Medical Association, of which he has been a member since 1929. He is also past-president of the Dallas Southern Clinical Society, the Texas Society of Gastroenterologists and Proctologists, and the Texas Medical Association.

A diplomate of the American Board of Internal Medicine and of the subspecialty Board of Gastroenterology, Doctor Rouse is a fellow of the American College of Physicians. Doctor Rouse is active

in church and civic affairs and is a member of several such organizations.

The new president, who is a past president and former chairman of the Board of Trustees of the Cleveland Medical Library Association, is a trustee of the Cleveland Welfare Federation, and a member of several committees of the Federation. Doctor Hudson is a diplomate of the American Board of Internal Medicine. In addition to his practice as a member of the department of internal medicine of the Cleveland Clinic, he is an associate clinical professor in medicine at Western Reserve University.

Governor Appoints Dr. Payne To State Health Board

Gabe A. Payne, Jr., M.D., Hopkinsville, was appointed to serve on the State Board of Health by Governor Edward Breathitt on July 8. He succeeds O. Leon Higdon, M.D., Paducah, whose term expired.

A KMA trustee from the third district, Doctor Payne has also been a delegate to KMA and is a past president of the Christian County Medical Society. A member of the Governor's Health Advisory Council, he has long been active in local civic and church affairs. In 1958 he was a member of a medical mission team which made a round-the-world tour.

Doctor Higdon represented the first district on the Board of Trustees, was KMA vice president in 1956, and an alternate delegate to the AMA in 1954-5. He has been president of the State Board of Health. While a KMA delegate, he was especially active in insurance and legislative fields.

"Dry-Run Accreditation Teams Visit 12 Hospitals

The Kentucky Medical Association has participated in twelve "dry-tun" hospital accreditation visits during the past year, setting a new record for the number of annual visits made, according to James Holloway, M.D., Lexington, chairman of the KMA Hospital Committee, under whose guidance the "dry-run" teams function.

The purpose of the teams is to visit on request hospitals desiring to become accredited by the Joint Commission on Accreditation of Hospitals and to assist them in attempting to raise the standard of care in the hospitals throughout the Commonwealth of Kentucky.

The "dry-run" accreditation visit program, initiated in 1962, by KMA, is a cooperative effort of the Kentucky Medical Association, Kentucky Hospital Association, and Kentucky Association of Medical Record Librarians. Each of the above organizations are represented on the "dry-run" teams which are currently being expanded from three to six teams of four members each due to the increasing number of requests for "dry-run" accreditation visits.



During the Inaugural Ceremony at the AMA Convention, June 28, Chicago, James Z. Appel, M.D., Lancaster, Pa., (right) was presented the Past President's Medal. Congratulating him for his year's presidency were Wesley W. Hall, M.D., Reno, Nev., (left), vice-chairman of the AMA Board of Trustees, acting for Percy E. Hopkins, M.D., Chicago, chairman of the Board of Trustees, and Charles L. Hudson, M.D., Cleveland, (center) newly installed AMA president. Doctor Hall has since been elected chairman of the Board of Trustees.

Each team spends approximately five hours inspecting the requesting hospital and consulting with and advising the hospital staff. At the close of the day's activities, suggestions and recommendations as might be indicated are made by the team members for improvement of the hospital's operation. This valuable service is provided without cost to the hospital, and guidelines outlining the hospital's responsibilities in requesting such a visit have been published and distributed by the cooperating organizations.

Legislative Council Urges You To Check Voting Status

September 10 and November 8 mark two important days in 1966 for physicians and all citizens. The general elections will be held on Tuesday, November 8; and Saturday, September 10 at 1:00 p.m. is the registration deadline for the general elections, according to the KMA Council on Legislative Activities.

The importance of the elections this fall has been stressed over and over by all interested groups and individuals. Medicine has a prime interest in the outcome of the elections this year and every KMA member is urged to make sure that he, his family, office staff and friends are at least properly registered and then go to the polls and vote.

Your Council urges you to check with your county clerk to verify your voting status, especially if you have moved within the past year. Don't forget that you must be properly registered by September 10 if you are going to be eligible to vote on November 8.

Kentucky Well Represented At AMA Annual Meeting

J. Thomas Giannini, M.D., senior delegate from Louisville, led the Kentucky delegation, including delegates, John C. Quertermous, M.D., Murray, and Charles C. Rutledge, M.D., Hazard, at the 115th. Annual Meeting of the American Medical Association in June in Chicago.

(Continued on following page)

(Continued from preceding page)

Everett H. Baker, M.D., Louisville, KMA president; Robert E. Pennington, M.D., London, president-elect; and Mrs. Robert J. Salisbury, Mt. Sterling, president of the Woman's Auxiliary to the KMA, attended their respective meetings at the convention.

Kentucky's three alternate delegates, along with a number of other KMA members, attended the sessions of the House of Delegates. Alternates are: Charles G. Bryant, M.D., Louisville, William W. Hall, M.D., Owensboro, and David B. Stevens, M.D., Lexington. Each member of the Kentucky delegation was assigned specific reference committees to attend and reported their findings to the Kentucky delegation during caucus sessions.

Carroll L. Witten, M.D., Louisville, delegate of the AMA section on general practice served on the Reference Committee on miscellaneous business. Gratitude for the cooperation and participation of all Kentucky physicians attending the various meetings assigned to them was expressed by Doctor Giannini, the senior delegate.

Sam R. Ewing Joins KMA Staff As Executive Assistant

Sam R. Ewing, a native Kentuckian, has been appointed to the KMA staff as executive assistant, effective July 1, according to J. P. Sanford, KMA executive secretary. He replaces Thomas M. Temple who resigned to accept another position.



Before joining KMA, he was associated with Southern States Cooperative for 10 years as assistant manager of the Louisville wholesale branch.

A graduate of the University of Kentucky in 1941, Mr. Ewing is a Lt. Col. in the Air Force Reserve. He served with the Air Force during World War II in the European Theater and in the Korean conflict he was stationed in Japan and also served 2½ years in England.

Mr. Ewing is married and lives with his wife Katherine on Westport Road in Jefferson County.

Mrs. Kinsman Honored by WA-AMA

Mrs. J. Murray Kinsman, Louisville, was elected June 29, to the Board of Directors of the Woman's Auxiliary to the American Medical Association, during the organization's annual meeting in Chicago. Having just completed a term as the Auxiliary's Southern regional community service chairman, Mrs. Kinsman is a past president of the Woman's Auxiliary to the Kentucky Medical Association.

Mrs. Kinsman suffered a severe accident during the convention when she tripped on a chair and fell, breaking her hip. She has recently returned to Louisville from Chicago, where she was confined to a hospital for several weeks. She is among ten elected to serve the two-year term on the Board of Directors.



Officers of the Woman's Auxiliary to the KMA took time out during the AMA Annual Meeting to pose for a group picture. Standing are: Mrs. Charles C. Kissinger, Henderson, 2nd Vice-President; Mrs. Raymond E. Jones, Louisville, President-Elect; Mrs. Robert J. Salisbury, WA-KMA President. Seated are: Mrs. J. Murray Kinsman, Louisville, Past President and now National Director, WA-AMA; Mrs. Earl W. Roles, Louisville, National By-Laws Chairman; Mrs. James J. Rich, Lexington, Staff of M.D.'s wives.

Metropolitan Sponsors Seminar On Part B Medicare Program

More than 120 people attended the Orientation Seminar for the Medical Insurance Program of Medicare, (Part B), June 15, at the Executive Inn, Louisville, sponsored by the Metropolitan Life Insurance Company.

Top officials of the Company, which is the carrier for Part B in Kentucky gave the program following a luncheon.

KMA officials and representatives from each County Medical Society in the state were invited along with officials of the State Department of Health and allied groups.

George Wheatley, M.D., New York, senior medical examiner for the Metropolitan Company, who moderated the program, said he and other company officials present were well pleased with the attendance and the quality and large volume of questions asked.

Dr. Long Elected to AMA Comm.

Robert C. Long, M.D., Louisville, a member of the AMA Board of Trustees, was elected to the Executive Committee of the AMA Board at its re-organizational meeting June 30 immediately following the close of the 1966 Annual Meeting of the AMA House of Delegates. In addition, Doctor Long was re-elected as a member of the American Medical Association—Education and Research Foundation Board.

KMA Exec. Secretary Honored

Mr. Joseph P. Sanford, Executive Secretary of the Kentucky Medical Association, was installed as President of the Medical Society Executives' Association (MSEA) at the Association's annual meeting in Chicago on June 25.

MSEA is the national organization of all county, state, and national medical executives with a membership of over 400. Mr. Sanford will serve as President of MSEA until June, 1967.

Doctor Coe Re-Elected

Walter S. Coe, M.D., Louisville was re-elected president of the Kentucky Heart Association, June 9, at the KHA annual meeting in Louisville. Doctor Coe is associate editor of *The Journal of the Kentucky Medical Association* and associate clinical professor of medicine at the University of Louisville School of Medicine.

A 1943 graduate of the University of Louisville Medical School, he is also president of the Kentucky Society of Internal Medicine and former president of the Louisville and Jefferson County Heart Association. Doctor Coe is a former director of the Kentucky Heart Association.

Dr. James Given Appointment

Effective July 1, Grace M. James, M.D., Louisville pediatrician, was appointed to head the diagnostic and evaluation division of the Frankfort State Hospital and School, according to Dale H. Farabee, M.D., State Mental Health Commission. Doctor James' division is responsible for determining admission of mentally retarded persons to one of the State's two hospitals for the mentally retarded.

Doctor James, a 1950 graduate of Meharry Medical College, Nashville, has received postgraduate training in child psychiatry at Creedmoor State Hospital, and Albert Einstein College of Medicine, both of New York City. She has held appointments as instructor in child health and assistant clinical professor of pediatrics at the University of Louisville School of Medicine.

Dr. Moore Given Cancer Grant

A $170,000 grant from the cancer control section of the U.S. Public Health Service was presented in July to Condict Moore, M.D., associate professor of surgery, U. of L. Medical School. Doctor Moore will use the grant to teach physicians and dentists the diagnosis of mouth and throat cancer in their patients.

The grant, extended over a five year period, will also enable Doctor Moore to set up a clinic in Louisville General Hospital. The clinic and general educational program will be available to doctors in all fields of practice, according to Doctor Moore who has been associated with cancer research in Louisville for 15 years.

Ky. M.D. to Serve on S.S. Hope

Leonard J. Singerman, M.D., Pleasure Ridge Park, will soon begin a two-month voluntary tour of duty on the S.S. Hope, a hospital ship now on a medical teaching-treatment mission to Nicaragua. Doctor Singerman will be one of a 24-member rotating team to continue the medical instruction and treatment on board the ship and in shore-based clinics.

Doctor Singerman is a 1950 graduate of the Chicago Medical School, and specializes in internal medicine. Formerly in private practice, his new duty will include immunizing children against disease, treating patients and teaching modern medical techniques to the doctors, dentists, nurses and technicians of Nicaragua.

Kidney Research Grants Made

Three grants totaling $102,000 were awarded in June to the University of Louisville School of Medicine for use in kidney research. Grant pledges were made by the National Institute of Health, $85,000; the American Heart Association, $12,000; and the Kentucky Heart Association, $5,000.

Receiving the grants were Leonard B. Berman, M.D., and R. P. Misra, M.D., both of the University's kidney laboratory. The grants will enable research work on the membrane through which the kidney filters wastes, according to Doctor Berman.

U. of L. Asst. Deans Named

John W. Brown, Ph.D., Louisville, associate professor of biochemistry was named assistant dean of the graduate school, and Miss Patsy Ruth Allison, assistant dean of women at Eastern Kentucky University, Richmond, was appointed to a similar position by the University of Louisville Board of Trustees July 20. Doctor Brown, former associate dean of the U. of L. medical school, will act as liaison between the medical school complex and the graduate dean's office, according to John A. Dillon, M.D., U. of L. graduate dean. Miss Allison will replace Miss Barbara Burns.

Dr. Klicka Resigns as ARHI Pres.

Karl S. Klicka, M.D., resigned recently as president of the Appalachian Regional Hospital to accept a position in Michigan.

Doctor Klicka has been president of the ARHI, a non-profit system of nine community hospitals, since it began operation in October, 1963. He will leave office on September 9 to head up a multi-hospital system in Michigan. The Board of Trustees of ARHI has appointed a committee to find a new president and a medical director for the hospitals.

AMA Meeting News on FM Radio

Highlights from the American Medical Association Annual Convention, held June 26-30, Chicago, were broadcast for the first time over FM radio stations in three major areas of the U.S. The programs were presented twice daily as a service to physicians unable to attend the AMA meeting.

The programs were sponsored by the CIBA Pharmaceutical Company of Summit, N.J., according to Leonard Lewis, M.D., supervisor of convention coverage. The series was broadcasted by the National Service Network.

in diarrhea

LOMOTIL® Tablets / Liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



is a corker

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: 3 to 6 months — 3 mg. (½ tsp.* t.i.d.)
6 to 12 months — 4 mg. (½ tsp. q.i.d.)
1 to 2 years — 5 mg. (½ tsp. 5 times daily)
2 to 5 years — 6 mg. (1 tsp. t.i.d.)
5 to 8 years — 8 mg. (1 tsp. q.i.d.)
8 to 12 years —10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

NegGram

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Kentucky Registrants for AMA Annual Convention Chicago, June 26-30

One hundred and thirty-four Kentucky physicians registered at the American Medical Association's 1966 annual meeting, held in Chicago, June 26-30. This record was surpassed only by the Kentucky registration at the 1965 AMA meeting, in New York City, which numbered 136.

According to Lloyd W. Prang, director of the Physician Membership Records section of the AMA, 87 Kentuckians registered at the San Francisco meeting in 1964, and 94 attended the Atlantic City meeting in 1963.

Following is a complete list of Kentucky physicians who registered at the Chicago meeting this year:

Misak Abdukian, M.D., Lexington
William H. Anderson, M.D., Louisville
Marion E. Arnold, M.D., Madisonville
Everett H. Baker, M.D., Louisville
M. L. Barnes, M.D., Louisville
John T. Bate, M.D., Louisville
Charles B. Billington, M.D., Paducah
R. Glen Boles, M.D., Louisville
George F. Brockman, M.D., Greenville
David L. Brown, M.D., Lexington
Charles G. Bryant, M.D., Louisville
Lester R. Bryant, M.D., Lexington
William H. Bryant, M.D., Glasgow
W. M. Buttermore, M.D., Corbin
Frank R. Camp, Jr., M.D., Fort Knox
James C. Cantrill, M.D., Georgetown
M. A. Carnes, M.D., Lexington
Henry B. Caudill, M.D., Lawrenceburg
W. Air Clements, M.D., Ludlow
Norman G. Collier, M.D., Louisville
Emmanuel R. Coronel, M.D., Louisville
Norman K. Cohen, M.D., Louisville
Henry S. Collier, M.D., Louisville
Jack C. Collings, M.D., Owensboro
B. F. Combs, M.D., Lexington
Gordon K. Danielson, M.D., Lexington
Royce E. Dawson, M.D., Owensboro
Stephen G. Edelstein, M.D., Lexington
Carl F. Essig, Jr., M.D., Lexington
Sattar Farzan, M.D., Madisonville
Harold F. Funke, M.D., Crestwood
William C. Gardner, M.D., Madisonville
Dorothy G. Gates, M.D., Berea
J. Thomas Giannini, M.D., Louisville
Albert G. Goldin, M.D., Louisville
Armond T. Gordon, M.D., Louisville
G. Y. Graves, M.D., Bowling Green
John W. Greene, M.D., Lexington
George M. Gumbert, Jr., M.D., Lexington
De Lou P. Hall, M.D., Louisville
Michael M. Hall, M.D., Campbellsville
William W. Hall, M.D., Owensboro
Joseph Hamburg, M.D., Lexington
James D. Hancock, M.D., Louisville
John S. Harter, M.D., Louisville
Kenneth P. Haywood, M.D., Madisonville
Wallace E. Herrell, M.D., Lexington
Raymond Heitz, M.D., Louisville
J. R. Hill, M.D., Louisville
Paul E. Holbrook, M.D., Ashland
Anne H. Hopwood, M.D., Owensboro
Charles E. Hornaday, M.D., Owensboro
Darran N. Huggins, M.D., Henderson
Donald G. Hughes, M.D., Murray
V. A. Jackson, M.D., Lexington
Vernon L. James, M.D., Lexington
Charles B. Johnson, M.D., Russell
Coleman C. Johnston, M.D., Lexington
Michio Kaku, M.D., Fort Campbell
A. C. Kennedy, M.D., Henderson
David Y. Keith, Jr., M.D., Paducah
Toy E. Kingma, M.D., Fort Knox
Paul H. Klingenberg, M.D., Fort Mitchell
Raul C. G. Lago, M.D., Louisville
V. B. Lakhani, M.D., Harlan
Lloyd O. Larsen, M.D., Lexington
Robert Lich, Jr., M.D., Louisville
Robert C. Long, M.D., Louisville
Robert T. Longshore, M.D., Covington
Marvin A. Morris, M.D., Louisville
Ralph D. Lynn, M.D., Elkton
Dorothy Y. Ma, M.D., Louisville
Merle M. Mahr, M.D., Madisonville
W. C. Malette, M.D., Lexington
Eugene L. Marion, M.D., Glasgow
T. R. Marshall, M.D., Louisville
F. A. Martin, Jr., M.D., Paris
L. D. Mayer, M.D., Lexington
Guy Morford, M.D., Owensboro
Harold C. Morris, M.D., Louisville
O. B. Murphy, M.D., Lexington
Arthur J. Nash, M.D., Jenkins
Maurice Nataro, M.D., Louisville
Earl P. Oliver, M.D., Scottsville
Rudolf F. Noer, M.D., Louisville
Walter L. O'Nan, M.D., Henderson
B. L. Pederson, M.D., Lexington
Edmund D. Pellegrino, M.D., Lexington
Robert E. Pennington, M.D., London
Irving B. Perlstein, M.D., Louisville
F. M. Picklesimer, M.D., Paintsville
Nicholas J. Pisacano, M.D., Lexington
John C. Quertermous, M.D., Murray
Frank Radmacher, M.D., Louisville
Howard L. Ravenscraft, M.D., Hebron
Edward H. Ray, Jr., M.D., Lexington
Ben R. Reid, M.D., Louisville
Samuel E. Reynolds, M.D., Morehead
James S. Rich, M.D., Lexington
John A. Ritter, M.D., Harlan
Saul Rubin, M.D., Lexington
Russell R. Rudd, M.D., Fulton
Benjamin F. Rush, Jr., M.D., Lexington
Edward I. Rustin, M.D., Pikeville
Charles C. Rutledge, M.D., Hazard
N. A. Saliba, M.D., Louisville
Otto H. Salisbery, M.D., Covington
R. John Sanders, M.D., Owensboro
S. R. Scheen, M.D., Louisville
Carl H. Scott, M.D., Lexington
Robert D. Shepard, M.D., Lexington
Charles E. Shields, M.D., Fort Knox
George Shpilberg, M.D., Valley Station
Donn L. Smith, M.D., Louisville
Dixie E. Snider, M.D., Springfield
William W. Spalding, M.D., Louisville
Marion C. Spradlin, M.D., Somerset
Sheonath P. Srivastava, M.D., Harlan
David B. Stevens, M.D., Lexington
Borys Surawicz, M.D., Lexington
Janak R. Talwar, M.D., Lexington
W. Turton Thompson, M.D., Louisville
Fernando Pedro Tornaris, M.D., Glasgow
Jose Torres, M.D., Louisville
L. H. Wagers, M.D., Hazard
Claude C. Waldrop, M.D., Williamstown
Will W. Ward, M.D., Louisville
C. A. Wathen, M.D., London
Robert G. Wheeler, M.D., Georgetown
William Willard, M.D., Lexington
John D. Winebrenner, M.D., Louisville
Carroll L. Witten, M.D., Louisville
Frank L. Yarbrough, M.D., Owensboro

Pediatric Societies Merge

At the 7th joint meeting of the Kentucky Society of Pediatrics and the Kentucky Chapter, American Academy of Pediatrics, held in May in Owensboro, a merger was formed between the KSP and the KCAP. The organization will be known as the Kentucky Chapter of the American Academy of Pediatrics, according to Richard F. Greathouse, M.D., Louisville, vice-chairman.

A presentation was given by James Hughes, M.D., guest speaker from the University of Tennessee School of Medicine. The present officers of the KCAP will continue to serve as officers of the combined group. They are: Robert N. McLeod, Jr., M.D., Somerset, chairman; Doctor Greathouse, vice-chairman; and Noble T. Macfarlane, Jr., M.D., Lexington, secretary-treasurer. Among those continuing to serve on the executive committee are: Guy C. Cunningham, M.D., Ashland; John E. Bickel, M.D., Owensboro.

Correction

The Journal regrets an unfortunate error in the Scientific Article, "Tetanus Neonatorium", on page 573, in the July issue. The author, Walton M. Edwards, M.D., was erronously titled. The corrected footnote should read, Walton M. Edwards, M.D., associate professor of pediatrics, University of Louisville School of Medicine.


only one in the morning
and one in the evening

Now
b.i.d. convenience
plus
even greater patient savings
over q.i.d. tetracycline therapy

(plus all the advantages of tetracycline phosphate complex)

new Tetrex bidCAPS™*
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Maximum patient savings. New bidCAPS now enable you to prescribe tetracycline in an even more economical, more convenient form. Your patient's prescription dollar gets maximum value: a daily bidCAPS dose is priced lower than any other leading brand of tetracycline—b.i.d. or q.i.d.

Well tolerated. Tetrex (tetracycline phosphate complex) is well tolerated. Side effects are few and, to date, no photodynamic reactions have been reported.

More of the active antibiotic in the blood. The basic tetracycline in Tetrex (tetracycline phosphate complex) is less bound to serum protein than is demethylchlortetracycline.[1] Result: Tetrex (tetracycline phosphate complex) provides a higher percentage of active antibiotic in the blood.

Available in bottles of 16 and 50.

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BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms. *Contraindications:* The drug is contraindicated in individuals hypersensitive to tetracycline. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with tetracycline phosphate complex. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Mycotic or bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. *Usual Adult Dose:* 500 mg. b.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

References: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuhoric, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

Each bidCAP contains Tetrex (tetracycline phosphate complex equivalent to 500 mg. tetracycline HCl activity).

COUNTY SOCIETY REPORTS

McCracken

A special meeting of the McCracken County Medical Society was held at the Paducah Country Club on June 22. The meeting was called for the purpose of discussing billing procedures for doctors under the new Medicare Law, now in effect.

During the previous week, six members of the McCracken County Medical Society had gone to Louisville to meet with executives of Metropolitan Life Insurance Company, the designated carrier in Kentucky for the Part B portion Title XVIII of the Medicare Law. All members who attended felt that it was necessary for them to bring to the members of the Society that information that they had gleaned at the meeting. It was for this reason that the meeting was called by the president.

A panel type discussion was held with those membrs who had attended the meeting in Louisville as panelists. These included the President, Walter R. Johnson, Jr., M.D., Frank B. Crawford, Jr., M.D., secretary, and other members: James A. Harris, M.D., Ted Rosenberg, M.D., James C. Embry, Jr., M.D., and J. Vernon Pace, M.D., all of Paducah.

No old business, new business, correspondence, or other matters were discussed at the special meeting. There being no other business to come before the group, the meeting was adjourned.

Following is a list of recently reported county medical society officers. Others will be listed in September.

Mason

President, John T. Teegen, M.D.; secretary-treasurer, Claude E. Cummins, M.D.; delegate, H. N. Parker, M.D.; alternate, Robert M. Blake, M.D. All are from Maysville.

Owsley

Secretary-treasurer, M. B. Gabbard, M.D., Booneville; delegate, Doctor Gabbard.

IPMA Meeting Set for October

The 51st annual scientific assembly of the Interstate Postgraduate Medical Association will be held at the Sheraton Park Hotel in Washington, D.C., October 17-20. According to Edwin S. Hamilton, M.D., chairman, Board of Trustees, the Association is not a membership organization; it is open to any M.D. in the U.S. or Canada. Full details may be secured by writing Alton Ochsner, M.D., program chairman, Box 1109, Madison. Wisc., 53701.

KMA Adds New Member

A physician from Martin, Ky. was added to the KMA membership roster in June, according to the membership department. Frank G. Garbin, M.D., from Floyd County, is the new member.

Society for Cryo-opthalmology

The Society for Cryo-opthalmology, newly formed, is now accepting applications for membership. The Society will promote investigative and clinical applications of low-temperature technics to the eye. Inquiries and applications should be addressed to John G. Bellows, M.D., 30 North Michigan Blvd., Chicago 60620.

Nuclear Medicine Meeting Set

The annual meeting of the Southeastern Chapter of the Society of Nuclear Medicine will be held in Durham, N.C., November 3-5, according to C. Douglas Maynard, M.D., chairman of the scientific program. For further information, contact Doctor Maynard at Wake Forest College, The Bowman Gray School of Medicine, Winston-Salem, N.C., 27103.

Asst. Ed. Retires from Journal

Ann M. Huntsman, former Assistant Managing Editor for *The Journal of KMA,* retired in June from her editorial duties. Mrs. Huntsman has moved with her husband, a 1966 graduate of the University of Louisville School of Medicine, to Midland, Mich., where he has accepted a residency with the Midland Hospital Association. Mrs. Huntsman came to work for the *KMA Journal* in April, 1963.

Advertisement

General practice, Veterans Administration Nursing Home, Fort Thomas, Kentucky. Newly remodeled, well staffed, with all ancillary services available. 40 hour week, one month vacation each year, and excellent fringe benefits. Salary depending on qualifications. Attractive four bedroom house at modest rental available on grounds. Fort Thomas is a pleasant residential community across the river from Cincinnati. Excellent public and parochial schools. For additional information, call or write direct to Dr. Eugene Sterne, Chief of Staff, Veterans Administration Hospital, 3200 Vine Street, Cincinnati, Ohio, phone: 513-221-2325.

Anatomy of
Low Back Pain #1



the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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263013

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305, 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

RAUTRAX®-N

Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

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B and C vitamins are part of therapy: An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, are formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.



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Each capsule contains:

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Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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Establish and maintain early, more decisive control of blood pressure

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Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

When blood pressure won't stay down despite initial therapy — when complaints of headache, fatigue or dizziness are often voiced — it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine *plus* cryptenamine — a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension) —"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension.
Dosages: Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.
*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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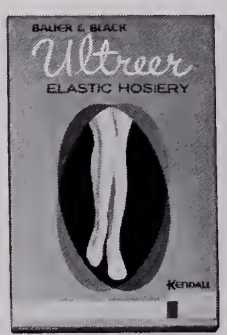
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Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

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In Memoriam

MARK DEMPSEY, M.D.

Garrett, Ky.

1875-1966

Mark Dempsey, M.D., Garrett, died Sunday, June 3, at his home. Doctor Dempsey, age 91, had been a general practitioner in the Garrett community for many years.

Doctor Dempsey received his medical degree in 1907 from the Hospital College of Medicine in Louisville. He had devoted his lifetime to the practice of medicine in Floyd County.

DILLARD D. TURNER, M.D.

Frankfort, Ky.

1905 - 1966

Dillard D. Turner, M.D., 61, director of local health for the State Department of Health, died Thursday, July 15, at the Central Baptist Hospital, Lexington, after suffering a coronary thrombosis. Doctor Turner, who had been in public health work since 1934, had served as health officer for the counties of Leslie, Perry, Lyon, Livingston, Caldwell and Crittenden. A 1934 graduate of the University of Louisville Medical School, he took his postgraduate work in public health at Johns Hopkins University.

NEWS ITEMS

F. A. Martin, M.D., Lexington, who has maintained an office on East Fifth St., has moved his office to the Medical Center on Lexington Road as of June 20th. Doctor Martin will occupy the office formerly occupied by W. L. McCleod, M.D., who recently returned to his practice in North Carolina.

Albert S. Irving, M.D., Louisille, who has been active in KMA Committee work for many years, has retired as Vice-President and Medical Director of the Commonwealth Life Insurance Company in Louisville, as of July 1. Doctor Irving will remain in Louisville.

Alvin D. Poweleit, M.D., Covington, departed July 10 for Charleston, S.C., where he is stationed as a lieutenant-commander with the Navy. Doctor Poweleit is a 1936 graduate of the University of Louisville School of Medicine, who shares his practice with his father, Alvin C. Poweleit, M.D., a World War II veteran. He will be eligible for discharge in September.

(Continued on Page 714)

MEN'S SHOP



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1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
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Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy

(Continued from Page 711)

Charles W. Mercer, M.D., Murray, joined the staff of the Houston-McDevitt Clinic, as of July 5. Doctor Mercer, a 1960 graduate of the University of Louisville School of Medicine, served his internship and assistant residency in medicine at Jackson Memorial Hospital and University of Miami School of Medicine in Miami. Having finished his service in the U.S. Air Force, he returned to University Hospital in Lexington, in 1965, and worked as assistant resident in medicine, chief resident in medicine and postgraduate fellow in cardiology.

Imogene Fairchild, M.D., Louisville has accepted a position as associate superintendent at the Wyoming State Hospital, Evanston, Wyo. Doctor Fairchild, a psychiatrist, was formerly located at Central Hospital.

Paul F. Maddox, M.D., Campton, was presented with the Outstanding Alumnus Award by the Morehead State University Alumni Association in June at the University.

Mary Pauline Fox, M.D. is resigning the position of Regional Health Director of the Hazard office. Doctor Fox has been appointed Assistant Medical Director of Frontier Nursing Service at Hyden.

Robert G. Spurling, M.D., Louisville, who limits his practice to pediatrics has opened an office at the Brownsboro Medical Center. A 1961 graduate of the University of Louisville Medical School, Doctor Spurling served his residency at Children's Hospital, Louisville.

Wayne C. Liles, M.D., Winston-Salem, N.C., has announced that he has joined the staff of the Henderson Clinic in Morganfield, in July. Doctor Liles received his B.S. and M.D. degrees from the University of Alabama and served his internship under sponsorship of Baylor University at Jefferson Davis Hospital in Houston, Texas. After two years in the Air Force, he started his general surgery training, serving two years of his residency at University Hospital, Birmingham, Ala., and two years at Forsyth Memorial Hospital, Winston-Salem.

W. Pat Mazier, M.D., Louisville, opened an office in July to begin his practice. Doctor Mazier, a 1963 graduate of the University of Western Ontario Faculty of Medicine, London, Ontario, served his internship at Victoria Hospital, London, Ontario and his residency at Louisville General Hospital. He previously had a general practice in London, Ontario, before coming to Louisville, in 1964.

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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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W. A. Litzenberger, M.D., Elizabethtown, has announced his association with **William R. Handley, M.D.**, for the practice of internal medicine, as of July 11. A 1960 graduate of the University of Louisville School of Medicine, Doctor Handley interned at Louisville General Hospital and served two years in the U.S. Air Force. He recently completed his residency in internal medicine at the University of Cincinnati hospital.

Robert W. Ridley, M.D., Louisville, has recently begun practicing in association with John J. Ryan, M.D., Louisville. Doctor Ridley, a 1962 graduate of the University of Chicago Medical School will limit his practice to ophthalmology.

Edward J. Shaw, M.D., St. Louis, has joined the staff of the Daniel Boone Clinic, Middlesboro, in June. Doctor Shaw, formerly located in St. Louis, held surgical staff positions with three hospitals. He is a graduate of Yale University School of Medicine, New Haven, Conn., and is a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons and the New York Academy of Medicine. Doctor Shaw is a former assistant clinical professor of surgery at New York Medical College, New York.

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Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

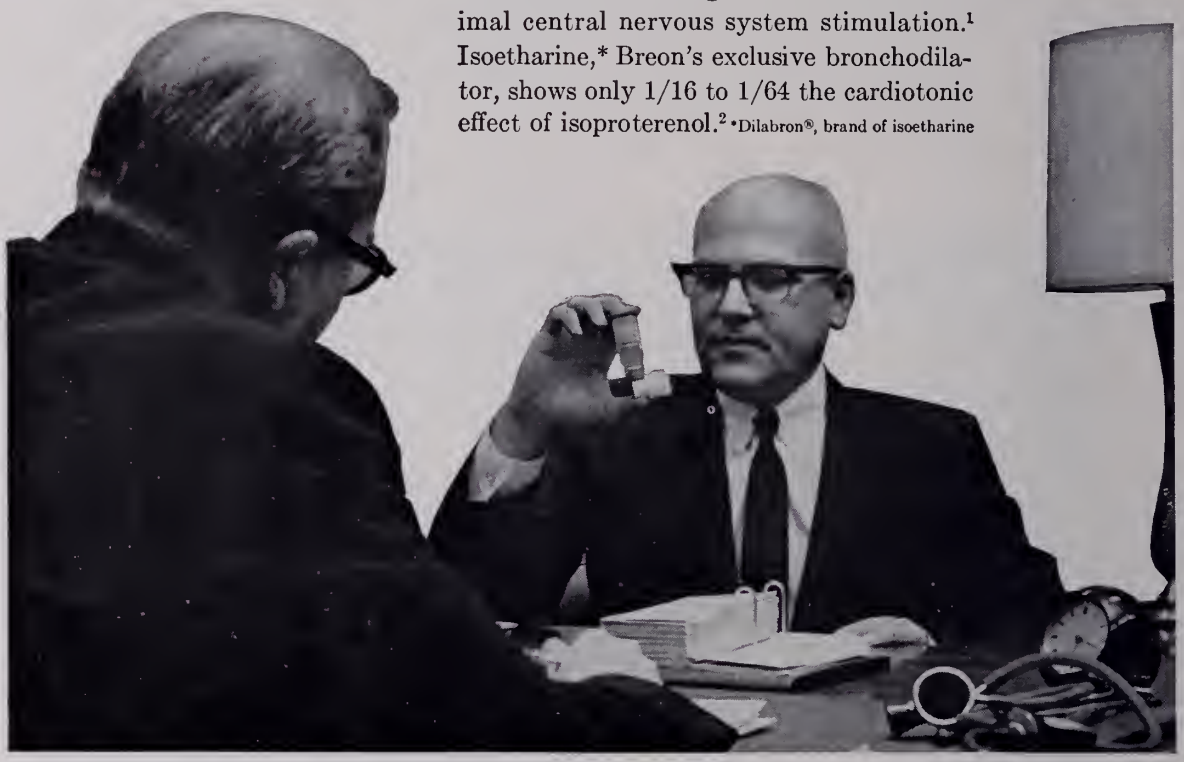
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isoetharine 0.6%; phenylephrine 0.125%; thenyldiamine 0.05%—Superior because it contains isoetharine

COMPOSITION: Bronkometer delivers at the mouthpiece 200 metered doses of: 350 mcg isoetharine methanesulfonate (0.6%); 70 mcg phenylephrine HCl (0.125%); and 30 mcg thenyldiamine HCl (0.05%) with saccharin, menthol and fluorochlorohydrocarbons as inert propellants. Preserved with ascorbic acid 0.1% and alcohol 30%.

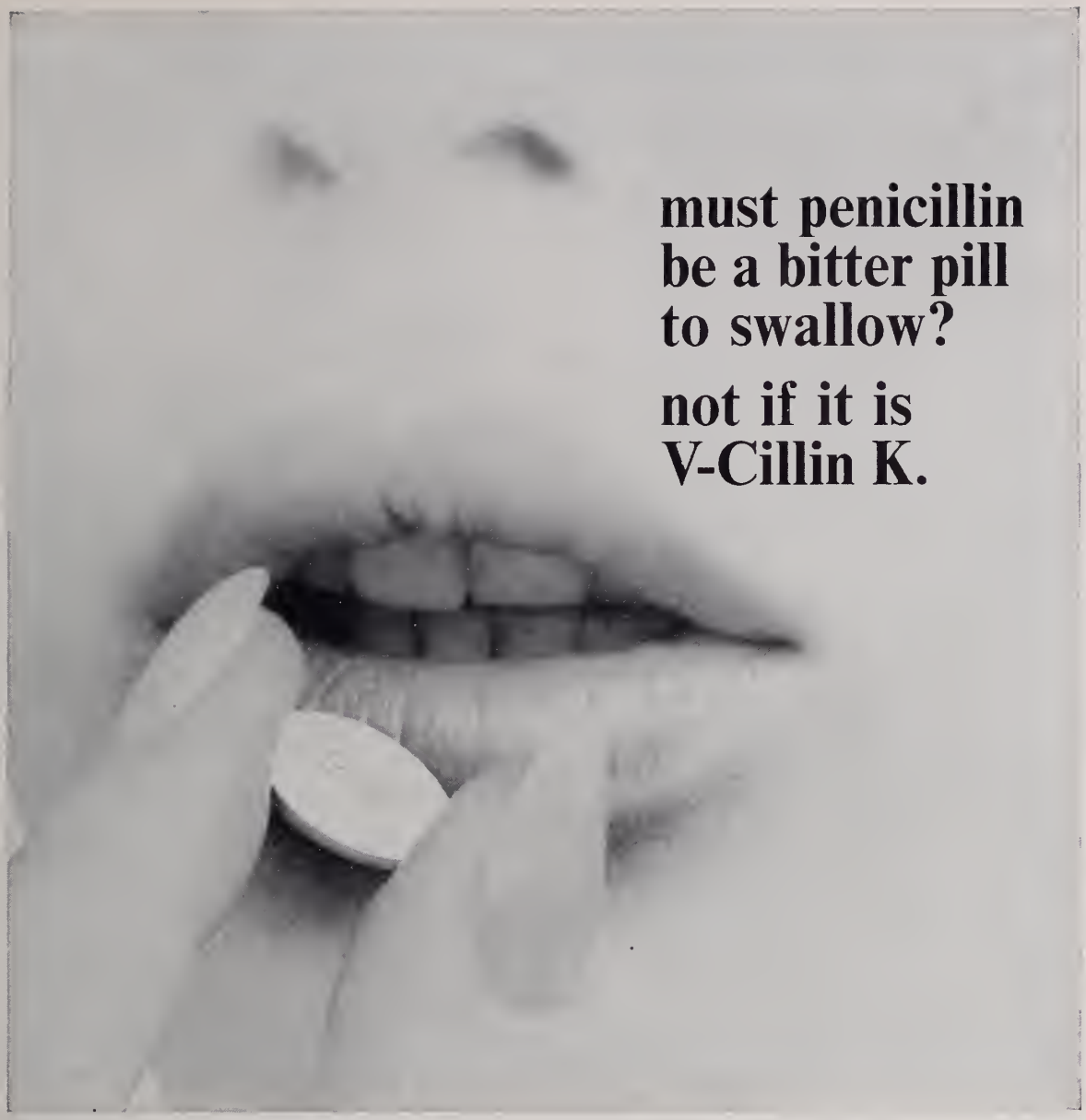
RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

PRECAUTIONS: Bronkometer is unusually free from cardiovascular and other side effects, but the usual precautions associated with sympathomimetic amines should be observed. Bronkometer should not be administered simultaneously with epinephrine or similar compounds because of the possibility of tachycardia, although it may be alternated with these agents. Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve and in individuals sensitive to sympathomimetic amines.

SUPPLIED: 10 ml pressurized aerosol vials complete with measured dose valve and oral nebulizer.

References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.

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THE other day I chanced upon a reprint of an editorial comment by H. L. Menkin which was originally published in the *American Mercury* in 1930. It was entitled "Lo, the Poor Bookseller" and is an analysis of the difficulties which the bookseller faced in the early part of the depression of the 1930's. Mr. Menkin devotes nearly half of his editorial to what he calls "the cheap book experiment." He seems to have included in this "cheap book" class, all books that were to be sold for less than $2.50, regardless of their literary merit. These comments referred to another of a long series of "experiments" in the publishing of inexpensive books which had been attempted first in Great Britain as early as the later decades of the 18th century. Numerous changes have taken place in the book trade over the past 35 years, not the least of which is the production of very inexpensive books.

Medical and scientific books have generally been more costly than contemporary publications in other fields, and the cost of old, long out-of-print, now "classical" monographs in these areas of endeavor have risen to exorbitant heights. All of the major book publishers and many of the university presses at home and abroad have attempted to meet the "needs" of the medical and scientific communities by the publication of low cost paperback editions. Book review sections in our periodicals seldom consider this special class of published material for there are few entirely new books (except texts) which appear in this form. The majority of the "paperbacks" in medicine and science are reprints of "classics" or collections of papers relating to a single subject. These are given a new introduction, an attractive cover, and are offered for sale at reasonable prices. Unfortunately, if one does not peruse paperback booklists or entertain himself by scanning *Books in Print,* he may not know what is so readily available in this inexpensive form.

In an effort to call to your attention some of the publishers of medical paperbacks, I have appended here a much abbreviated list of books and their publishers that are currently available.

I hope that you may find among these some title in your particular area of interest.

Hafner Publishing Company—New York

The New York Academy of Medicine

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BURNS, ALLEN: *Observations on Some of the Most Frequent and Important Diseases of the Heart;* (No. 21), 1809, With an Introduction by Dr. Dickinson W. Richards.

CHARCOT, JEAN MARTIN: *Lectures on the Diseases of the Nervous System;* (No. 19) Delivered at La Salpetriere, 2 ser. 1881, Introduction by Dr. Walther Riese.

CORVISART, JEAN NICOLAS: *An Essay on the Organic Diseases and Lesions of the Heart and Great Vessels;* (No. 16), 1812, With an Introduction by Dr. Dickinson W. Richards.

HALES, STEPHEN: *Haemastaticks;* or *An Account of some Hydraulic and Hydrostatical Experiments Made on the Blood and Bloodvessels of Animals;* (No. 22), 1733, With an Introduction by Dr. Andre Cournand.

HEBERDEN, WILLIAM: *Commentaries on the History and Cure of Diseases;* (No. 18). 1802. With an Introduction by Dr. Paul Klemperer.

LAENNEC, R.T.H.: *A Treatise on the Diseases of the Chest;* (No. 17), 1821, With an Introduction by Dr. Paul Klemperer.

PINEL, PHILIPPE: *A Treatise on Insanity;* in which are contained the principles of a new and more prac-

tical nosology of maniacal disorders; (No. 14), Translated by D.D. Davis, M.D., 1806. With an Introduction by Dr. Paul F. Cranefield.

RAMAZZINI, BERNARDINO: *De Morbis Artificum—Diseases of Workers;* Chicago, English translation only from the Latin of 1713, (No. 23), 1940, With an Introduction by Dr. George Rosen.

RUSH, BENJAMIN: *Medical Inquiries and Observations upon the Diseases of the Mind;* (No. 15), 1812, With an Introduction by Dr. S. Bernard Wortis.

WOODWARD, J.J.: *Outlines of the Chief Camp Diseases of the United States Armies,* as observed during the present War; (No. 24), 1863, With an Introduction by Dr. Saul Jarcho.

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Clio Medica

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CORNER, G.W.: *Anatomy* (1930); 104 pages, ill. index.

DAWSON, WARREN R.: *The Beginnings: Egypt and Assyria;* (1930), 96 pages, Ill. index.

FORD, W.W.: *Bacteriology;* (1939), 244 pages, ill. index.

JAMESON, EDWIN: *Gynecology and Obstetrics* (1936); 150 pages, 5 ill. Bibliog., index.

KRUMBHAAR, E.B.: *Pathology;* (1937), 218 pages, ill. Chronol., list of pathological milestones, index.

LUSK, GRAHAM: *Nutrition;* (1939), 160 pages, ill. index.

STONE, E.P.: *Medicine Among the American Indians;* (1932), 139 pages, 17 ill. Map. index.

Dover Publications, Inc.—New York, N.Y.

BEAUMONT, WILLIAM: *Experiments and Observations on the Gastric Juice and The Physiology of Digestion;* (1833, 1902), Biographical Essay by William Osler. $1.50.

BERNARD, CLAUDE: *An Introduction to the Study of Experimental Medicine;* (1927), Trans. by H.C. Greene, Introduction by L. J. Henderson. $1.50.

CAMAC, C.N.B. Ed: *Classics of Medicine and Surgery;* (1909), $2.25.

CARDAN, JEROME: *The Book of My Life;* (1930), Trans. by J. Stoner. $1.60.

CLENDENING, LOGAN: *Source Book of Medical History;* (1942), $2.75.

DARWIN, CHARLES: *Autobiography and Selected Letters;* (1892), Ed. by Francis Darwin. $2.50.

KEYS, THOMAS E.: *The History of Surgical Anesthesia;* (1945, 1963), 2nd rev. ed. $2.00.

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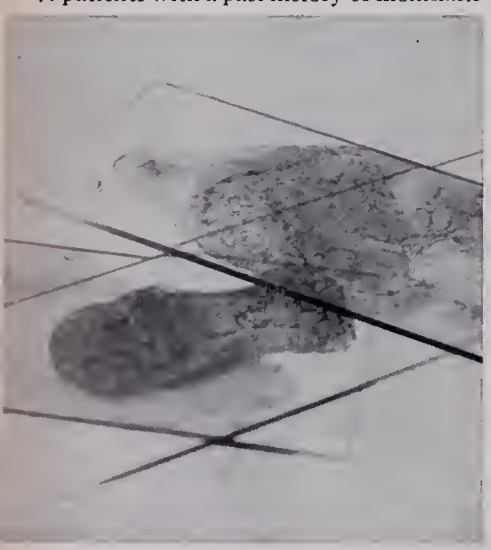
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Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

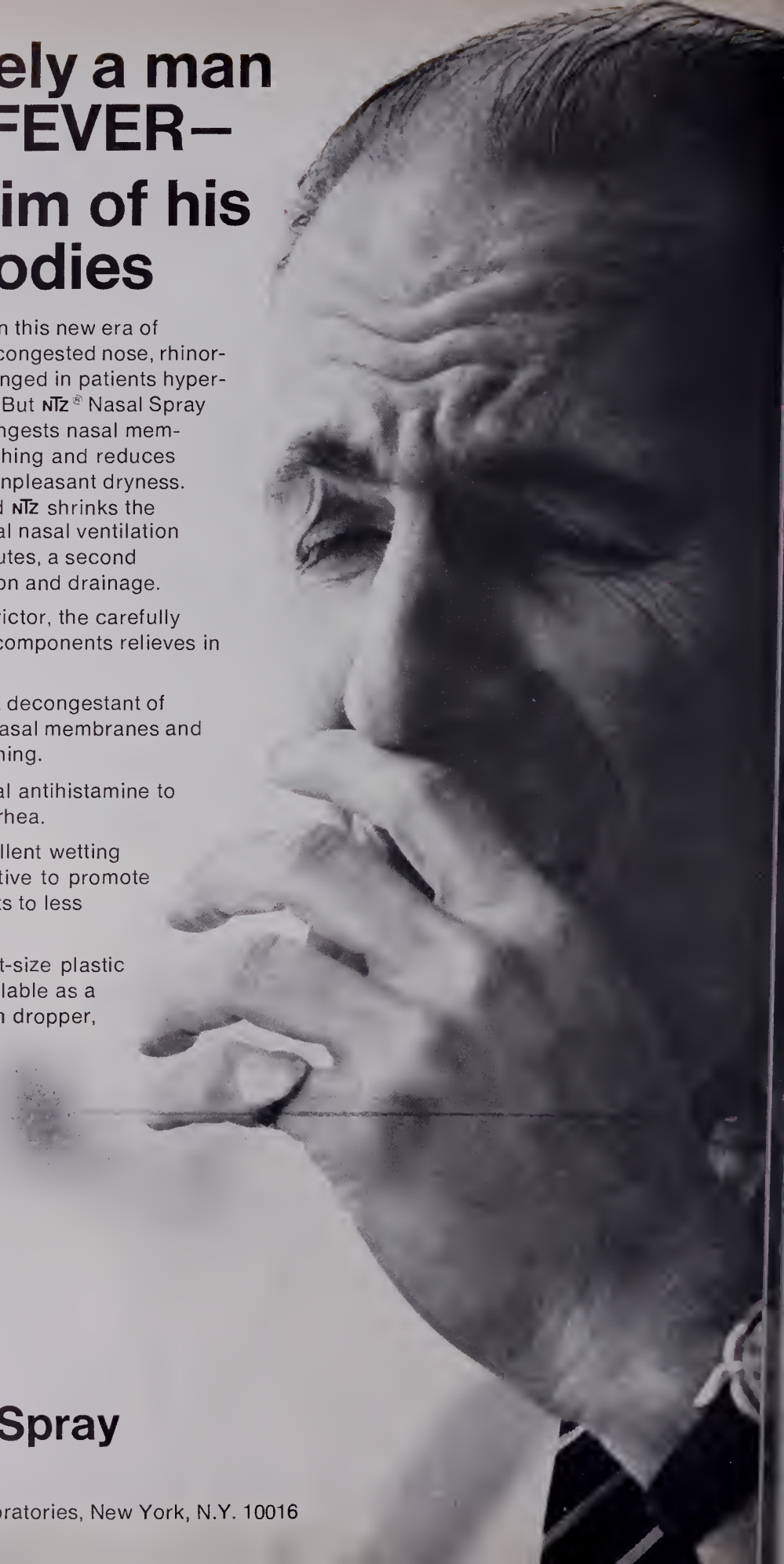
Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Meprotabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

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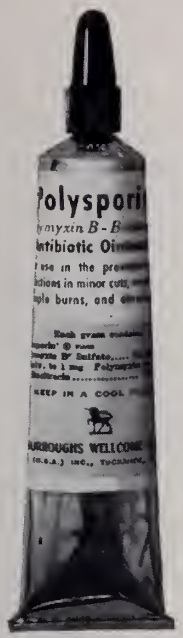
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this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

Barry Belonsky, M.D., F.A.C.A.
Staff Anesthesiologist, Hospital of The Albert Einstein College of Medicine, New York City



Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care requiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.[1] In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out",[2] a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.[3]

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result from secretions penetrating the bronchi and bronchioles. In laryngospasm, there are both inspiratory and expiratory stridor and difficulty in inflating the chest; in bronchospasm there is an expiratory wheeze, but not as much difficulty in inflation, although some resistance may be felt. Stridor is due to partial or complete closure of the vocal cords in spasm and the "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produces *difficulty in ventilation* through the mouth until the patient is deep enough to place an oral airway. An intravenous agent can be given to facilitate the induction of anesthesia.

Difficulties can arise if intubation is performed to ventilate the patient. For example, teeth can be broken by too vigorous attempts at intubation, or the intubation itself may be technically difficult due to secretions obstructing the view of the glottis. The postoperative sequelae of intubation ranges from mild laryngitis to pneumonia with atelectasis, and are seen far more commonly in patients suffering from colds than in normal patients.



Successive stages of laryngospasm which produce the characteristic stridor or "crowing" sound.



Progression of bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intra-anesthesia complications, and occur much more frequently in a patient who has been intubated.[4]

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment[5,6,7,8] consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

(concluded on following page)



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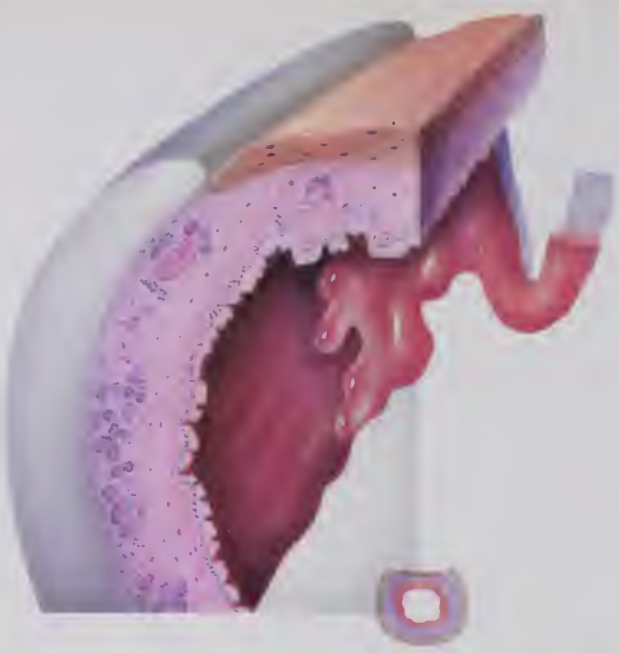
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Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions become more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary: Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

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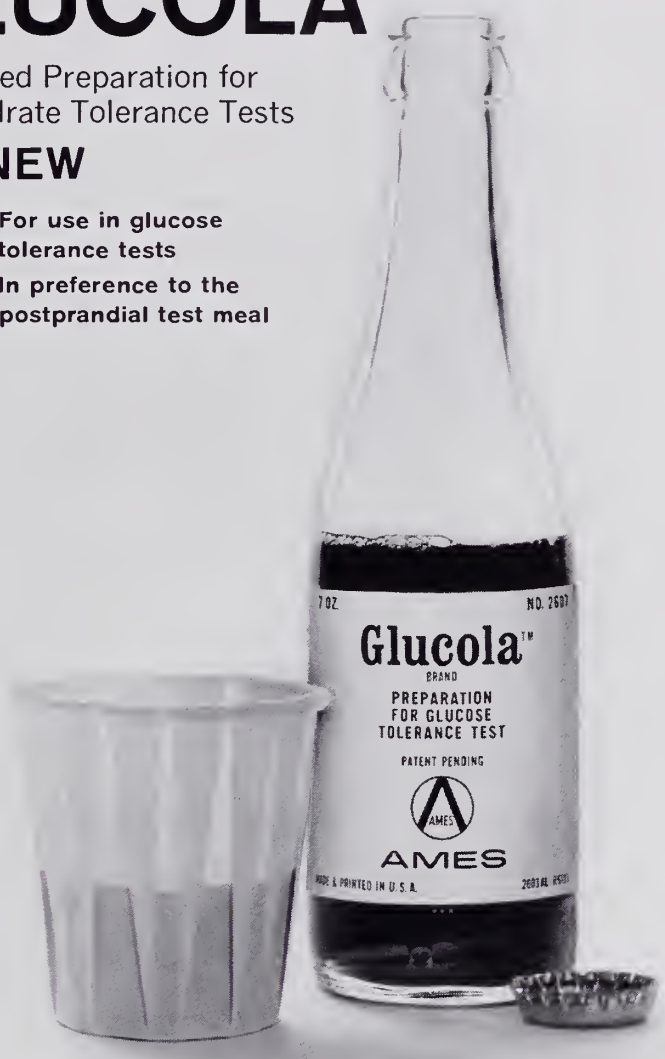
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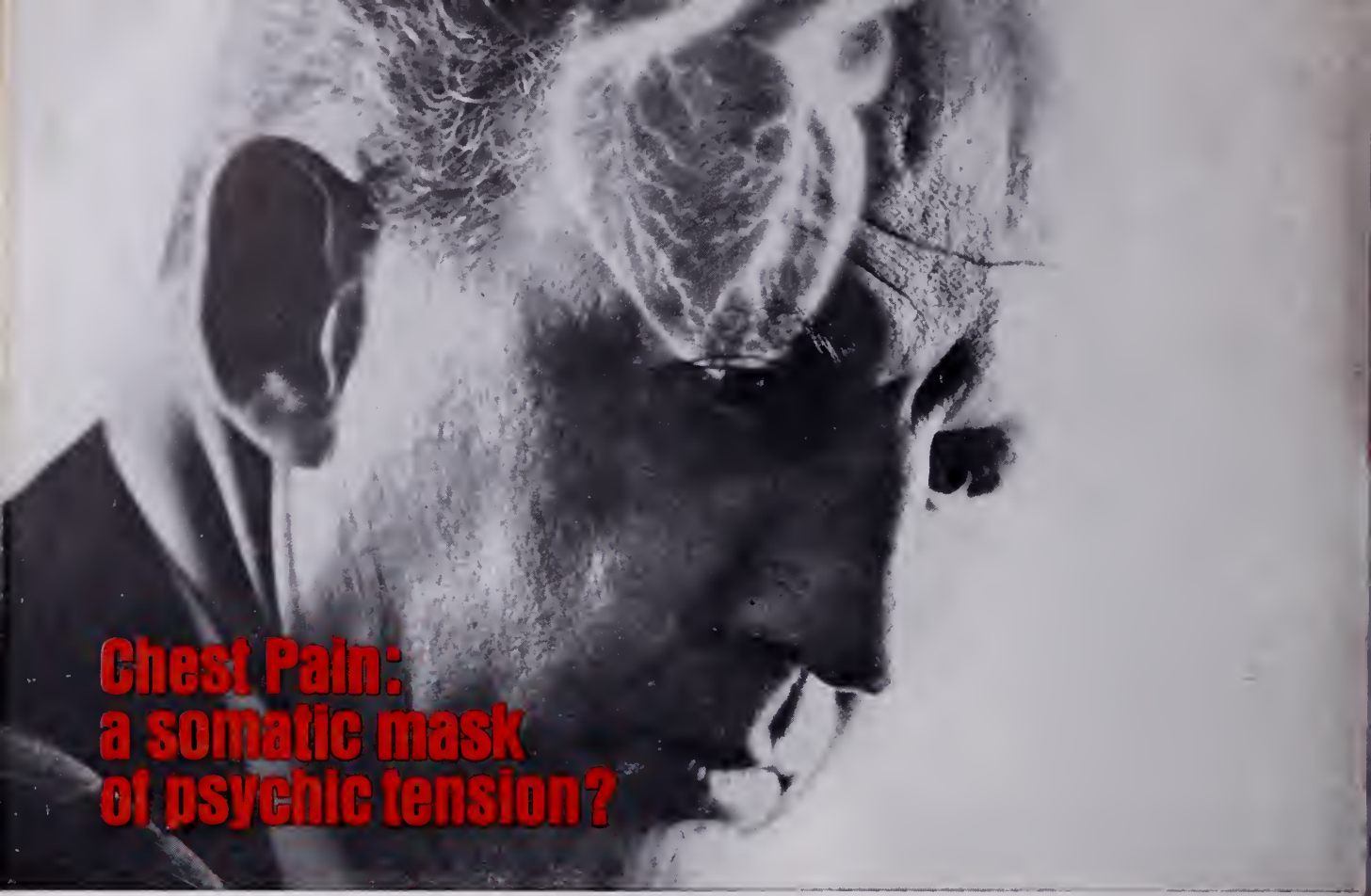
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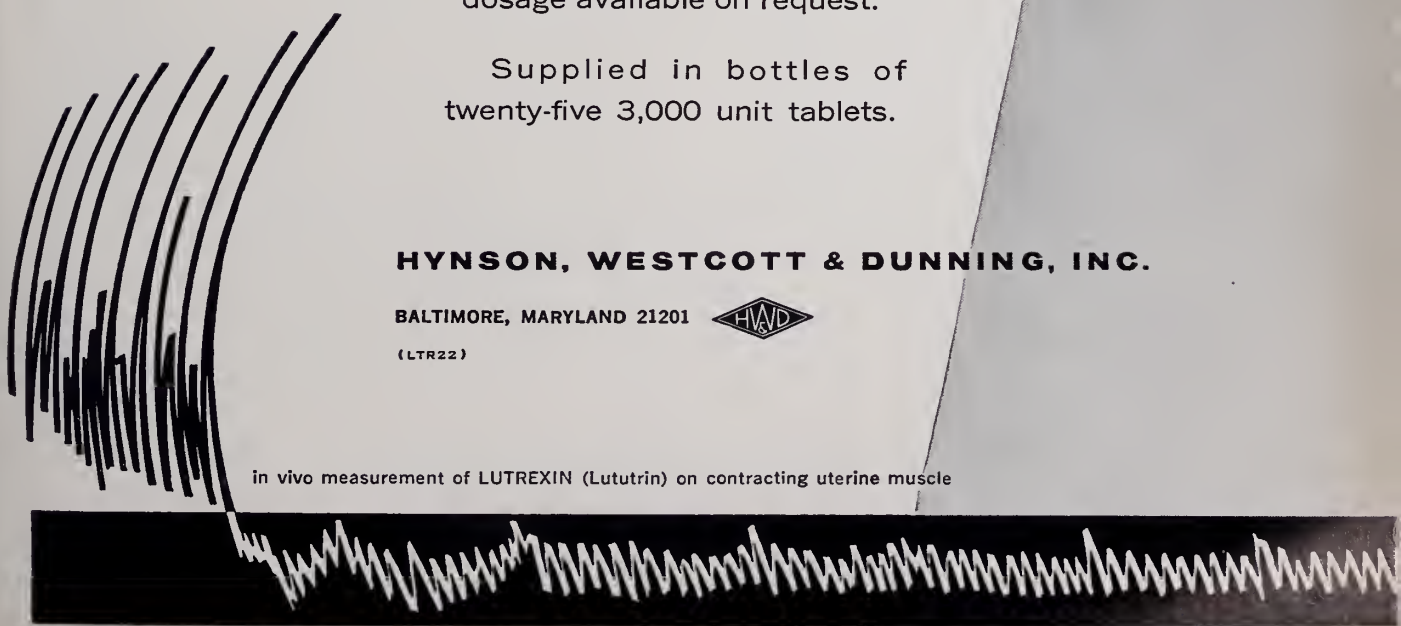
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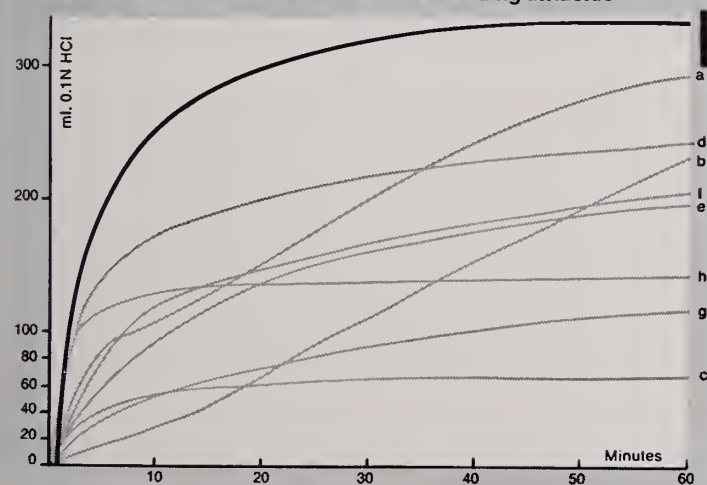
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In recent laboratory comparisons* with eight other leading antacids, new WinGel tablets not only neutralized more hydrochloric acid per active-ingredient weight, but neutralized it faster and longer than all other antacids tested.

Pleasant pink in color, WinGel is delicately mint flavored with a smooth-as-cream texture—qualities sure to please the patient on long-term therapy. New WinGel is also specially formulated to avoid constipation or diarrhea.

New WinGel neutralizes 300 times its active-ingredient weight in 0.1N hydrochloric acid—neutralizes more acid faster than other leading antacids



Rate of 0.1N hydrochloric acid neutralization at pH 3.5 and 37° with WinGel and eight other leading antacid tablets—*in vitro*. Samples equaled the weight of tablet material containing 1.0 Gm. active ingredients.*

*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

Dosage: Peptic ulcer or gastritis—from 2 to 4 teaspoons of WinGel liquid or 2 to 4 tablets chewed or allowed to dissolve in the mouth every two to four hours. **Gastric hyperacidity**—2 tablets or teaspoons about ½ to one hour after meals as needed; children from 7 to 14 years of age, 1 or 2 tablets or 1 or 2 teaspoons of liquid as needed.

How Supplied: Liquid in bottles of 8 fl. oz. and 1 pint. **Tablets** in cellophane strips, boxes of 50 and 100. (One teaspoon of WinGel liquid is equivalent to one WinGel tablet in acid-combining capacity.) WinGel, trademark reg. U.S. Pat. Off.

Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Finally — a taste your patients will truly like

(1058M)



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown®
(meprobamate)

Indications: Meprobamate is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, meprobamate fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Meprotabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

WALLACE LABORATORIES
Cranbury, N.J.

CM-7814



Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB *'The Priceless Ingredient' of every product is the honor and integrity of its maker.*

MESSAGE FROM THE PRESIDENT



Medical Meetings

WITH the advent of fall, doctors of medicine become involved anew in professional meetings. Autumn descends on us in Kentucky as the KMA physicians and guests gather at the Convention Center in Louisville for our 115th annual meeting. The program and exhibits have been carefully prepared for our continued education and enjoyment.

The luncheon speaker on Wednesday noon, September 21st is the brilliant, well known and widely traveled physician—Walter H. Judd, M.D. Place this date and time at the top of your agenda for attendance by yourself, your associates, your family and your friends. His message will bring us the National and International picture as no one else can better portray.

Leaders in medical education will bring to us the most recent advances and opinions from many centers. We will have the opportunity to listen, ponder, absorb and discuss the scientific and socio-economic changes that constantly appear.

We are all pupils in the school of life. Our minds are finite and we profit by every experience. We walk by such light as we have and we wish to be loyal to the truth we know.

Teaching is provocative and paradoxical. There are no pat rules of thumb. Obstacles, mists and mystery prevent a perpetual blue sky overhead. Smooth sailing forever is not our lot.

This gives intellectual curiosity and we live with zest, wonder and awe. Then we venture into investigation and research, so much a part of our life today.

Unamuno, the Spanish philosopher-mystic gave to us the most startling benediction in concluding his book, *The Tragic Sense of Life,* with these words: "May God deny you peace, but give you glory".

Everett H. Baker

Everett H. Baker

Night Leg Cramps...Frequent Bedfellow

In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]



now...specific therapy for night leg cramps

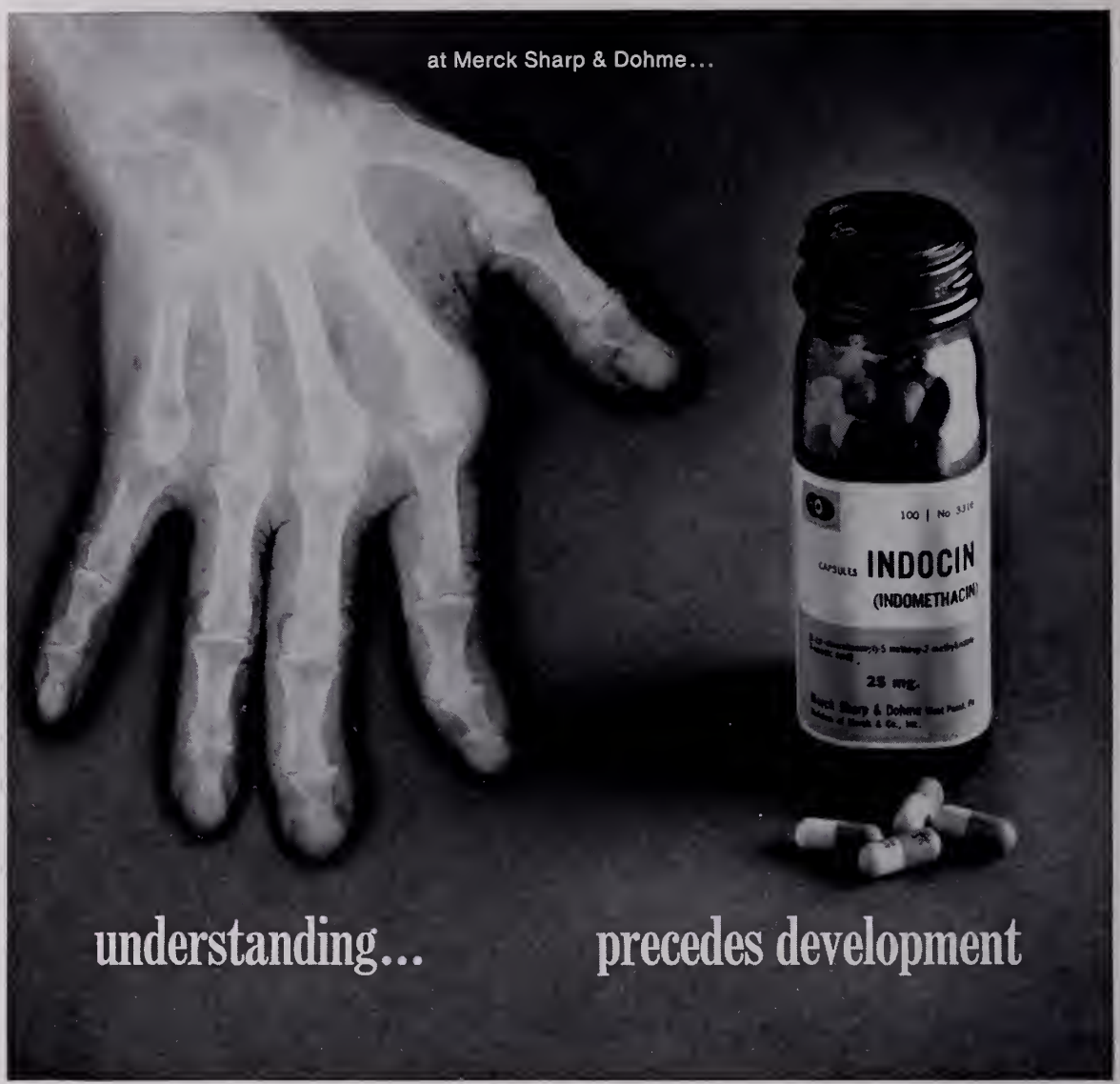
QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

QUINAMM Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 4 grains (250 mg.) and Aminophylline 3 grains (200 mg.). **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **Caution:** Federal law prohibits dispensing without prescription.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

WALKER *Laboratories* Division of Richardson-Merrell Inc., Mount Vernon, New York 10551



The synthesis of cortisone was accomplished by Merck Sharp & Dohme in 1948—the famous "Compound E" used by Dr. Philip Hench in his historic experiment at the Mayo Clinic.

But proud as we are of our role in the development of cortisone and subsequent corticosteroids, we have continued to seek a greater understanding of arthritic disorders and new drugs for their treatment.

One such drug—INDOCIN® (indomethacin), a nonsteroid, anti-inflammatory agent fundamentally different in structure and activity from other drugs in use—was recently made available for the treatment of arthritic conditions. It opens new possibilities for the long-term management of arthritis and inflammatory disease.

MSD **MERCK SHARP & DOHME** | **where today's theory is tomorrow's therapy**
Division of Merck & Co., INC., West Point, Pa.

INDOCIN®

INDOMETHACIN

Indications: Chronic and acute rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.
Contraindications: Active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis. Safety in pregnancy has not been established. Not recommended for pediatric age groups.
Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.
Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.
Before prescribing or administering, read product circular with package or available on request.



This year...vacation in KENTUCKY'S 40 STATE AND NATIONAL PARKS

Some are rich in history *(like Fort Boonesborough)*, some in tradition *(like My Old Kentucky Home)*, some in scenery *(like Cumberland Gap)*, some in natural marvels *(like Mammoth Cave)*, some in magnificent accommodations *(like any of the 12 state resort parks)*. Whatever your sport or pastime, you can spend many happy weeks exploring Kentucky's great chain of state and national parks. This year . . . join the nation in a Kentucky vacation!

Send for exciting vacation literature.

Travel Division, Public Information Dept.
Capitol Annex Building, Frankfort, Ky.
Department

Please send me complete information on how to have the best vacation ever at Kentucky's State Resort Parks.

Name _____

Address _____

City _____

State _____ Zip _____



Butazolidin® alka

phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
6509-V(B)

Also available: Butazolidin®, phenylbutazone Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York BU-3804R

Geigy

ANNOUNCING a potent combination in truly delicious orange-flavored forms:

ERYTHROCIN®-SULFAS

ERYTHROMYCIN ETHYL SUCCINATE–TRISULFAPYRIMIDINES



When combination antibiotic therapy is indicated...



CONSIDER: an exceptionally high cure rate in susceptible infections

The rationale: When combined, Erythrocin and the trisulfapyrimidines (triple sulfas) are indicated in infections that are more susceptible to the combination than to either agent alone. Such conditions are usually found in urinary, lower respiratory tract and chronic ear conditions.

The results: Clinical studies involving 142 young patients showed *an overall cure rate of 96.5%*. Side effects were experienced by only four of the patients.

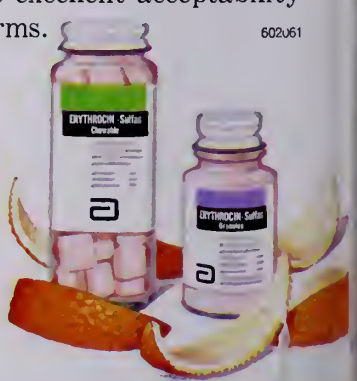
The acceptance: The majority of the 142 patients studied expressed a definite liking for the products. *There were only two refusals.* An independent taste-test with 50 healthy children further substantiated the excellent acceptability of the orange-flavored forms.

602v61

ERYTHROCIN®-SULFAS

ERYTHROMYCIN ETHYL SUCCINATE–TRISULFAPYRIMIDINES

In Chewable Tablets
In Granules for Oral Suspension



ERYTHROCIN-SULFAS
Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

ABBOTT

The discomforts of

DIARRHEA
MUCOUS COLITIS
DIVERTICULITIS
SPASTIC URETERITIS
BLADDER SPASM

are relieved by direct musculotropic action with.....

Trocinate®

BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly.

Administer 4 tablets every 4 hours until relief is constant, then adjust maintenance dosage.

Trocinate *BRAND* THIPHENAMIL HCl

Directly relaxes smooth muscle spasm
Combats hypermotility
Non-mydriatic, may be used in glaucoma

Sixteen years of clinical use, with absence of untoward effects, has established the safety and effectiveness of Trocinate.

Trocinate is metabolized in the body and completely eliminated, which is a safety factor. Dosage must be sufficient to maintain the therapeutic blood level.

DISPENSED IN BOTTLES OF
100, 250 AND 2000 TABLETS

Literature and samples sent upon request

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA
Manufacturers of ethical pharmaceuticals since 1856

An Opinion Survey of Kentucky Physicians On Health Aspects of Air Pollution†

Russell E. Teague, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

A RECENT survey of physicians was made in several Kentucky cities pertaining to the physicians' opinions regarding the effects of local air pollution on community health. During the interview, each physician was asked a series of questions that had been arranged before the interview in order that some continuity would be evident in tabulating the overall picture in a specific community. In one of the communities (Community X) in which the survey was conducted 20 physicians, representing approximately seventy per cent of the practicing general practitioners, pediatricians, opthalmologists, and public health physicians were interviewed. Fifty-five per cent of the physicians interviewed were of the opinion that atmospheric pollutants were present in sufficient concentration to cause mucous membrane irritations. Forty-five per cent of the physicians interviewed thought that air pollution concentrations in this Community X were sufficient to result in throat irritations and/or coughs, respiratory tract irritation, and allergic reactions. Thirty-five per cent attributed a major portion of eye irritations to air pollutants. Some of the physicians interviewed thought that air pollutants were of sufficient concentration to cause nausea and/or vomiting, gastro-intestinal tract irritation, headaches, permanent tissue damage, neurological disturbances, behavior disturbances, adverse psychologic reaction, and interference with learning.

Seventy-five per cent of the physicians interviewed were of the opinion that air pollution in Community X adversely affects their patients suffering from asthma and hay fever. Forty-five per cent of the physicians interviewed reported that air pollution adversely affects their patients suffering from emphysema and other respiratory conditions. Thirty per cent of the physicians interviewed reported adverse health effects on the patients suffering from colds and allergies such as dermatitis, allergic conjunctivitis, sinusitis, and otitis. A few of the physicians interviewed thought that air pollution adversely affected their patients with gastro-intestinal illnesses and heart conditions.

The physicians interviewed, reported that individuals less than seven and greater than 26 years of age were more adversely affected by air pollutants. However, the major emphasis was placed on persons 51 years of age and over with regard to adverse health effects as a result of exposure to atmospheric pollutants. During the last three years, 4,550 patients were seen by the physicians interviewed in which illnesses were produced by or contributed to by air pollutants. One death, from acute exposure, was reported in this same three-year interval. Thirty-five per cent of the physicians interviewed felt that illnesses and deaths resulting from air pollutants have been increasing during the last few years.

In the atmosphere of Community X, the pollutants which the physicians interviewed felt were potentially hazardous to health are as follows: industrial dust and smoke, coal smoke, ammonia, gasoline fumes and vapors, hydrogen chloride, other transportation exhaust, soot, industrial fumes, mist and vapors, pollen, molds, and fungi. Seventy per cent of the physicians thought that air pollution control is needed for Community X and eighty per cent of the physicians interviewed indicated that they would support Air Pollution Legislation.

The above findings were indicative of what was found in five other communities throughout the State in which a total of 74 physicians were interviewed.

The 1966 General Assembly passed air pollution control legislation, known as House Bill 259. This Bill created a Kentucky Air Pollution Control Commission within the State Health Department. The Commission consists of eleven members one of which is the Commissioner of Health.

The Air Pollution Control Program was established July 1, 1966, and is currently in the process of organization. As the Program develops, continued efforts will be made to assess the opinions of the medical profession on this important subject.

†*This article was prepared by Harold E. Hodges, B.Ch.E., M.P.H. and John T. Smither, B.A. Air Pollution Control Program Kentucky Air Pollution Control Commission Kentucky State Health Department 275 East Main Street Frankfort, Kentucky 40601*



incisive

A good way to describe 'Stelazine'. It's different from the tranquilizers that sedate and dull your anxious patients. Its antianxiety effect is direct. On 'Stelazine', your patients can be calmed yet remain alert.

And 'Stelazine' offers additional benefits. Dependence has not been reported. At low doses, side effects are minimal. Its b.i.d. dosage is convenient and economical.

Stelazine®

brand of **trifluoperazine**

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. *Contraindications:* Comatose or greatly depressed states due to C.N.S. depressants and in cases of existing blood dyscrasias, bone marrow depression and liver damage. *Precautions:* Use with caution in angina patients and in patients with impaired cardiovascular systems. Antiemetic effect may mask symptoms of other disorders. An additive depressant effect is possible when used with other C.N.S. depressants. Prolonged administration of high doses may result in accumulative effects with severe C.N.S. or vasomotor symptoms. Use in pregnant patients only when necessary for the patient's welfare. *Side Effects:* Occasional cases of mild drowsiness, dizziness, mild skin reactions, dry mouth, insomnia and amenorrhea. Neuromuscular (extrapyramidal) reactions (motor restlessness, dystonias, pseudo-parkinsonism) may occur and, in rare instances, may persist. In addition, muscular weakness, anorexia, rash, lactation, hypotension, and blurred vision have been observed. Blood dyscrasias and cholestatic jaundice have been extremely rare.

For a comprehensive presentation of 'Stelazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

Smith Kline & French Laboratories, Philadelphia SK&F

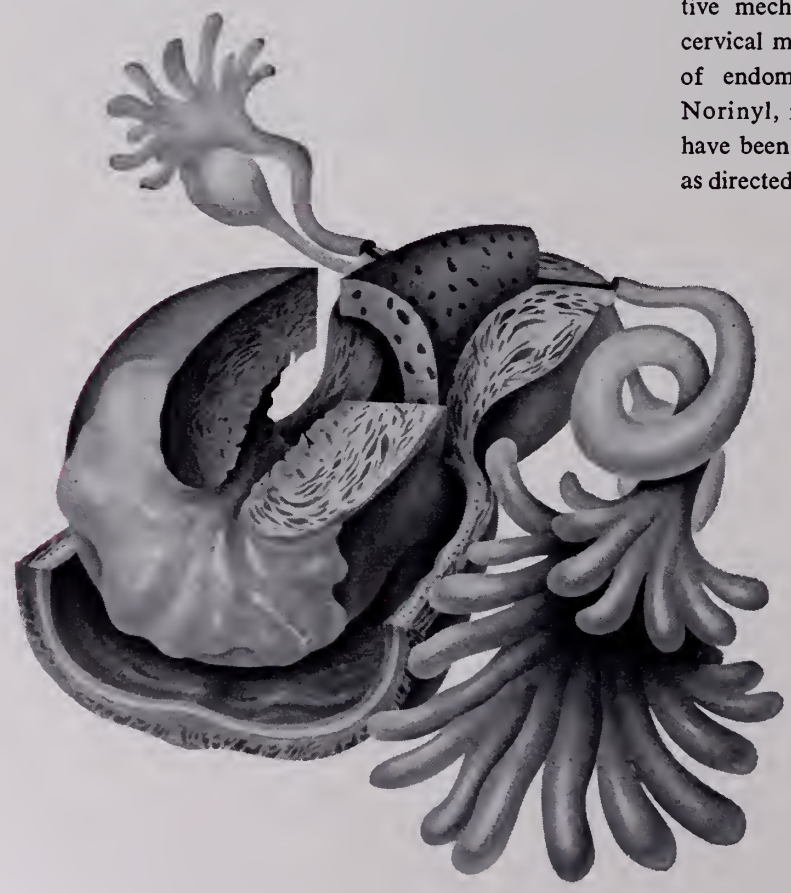
Norinyl® tablets
(norethindrone 2 mg. c mestranol 0.1 mg.)

for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation



no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.–mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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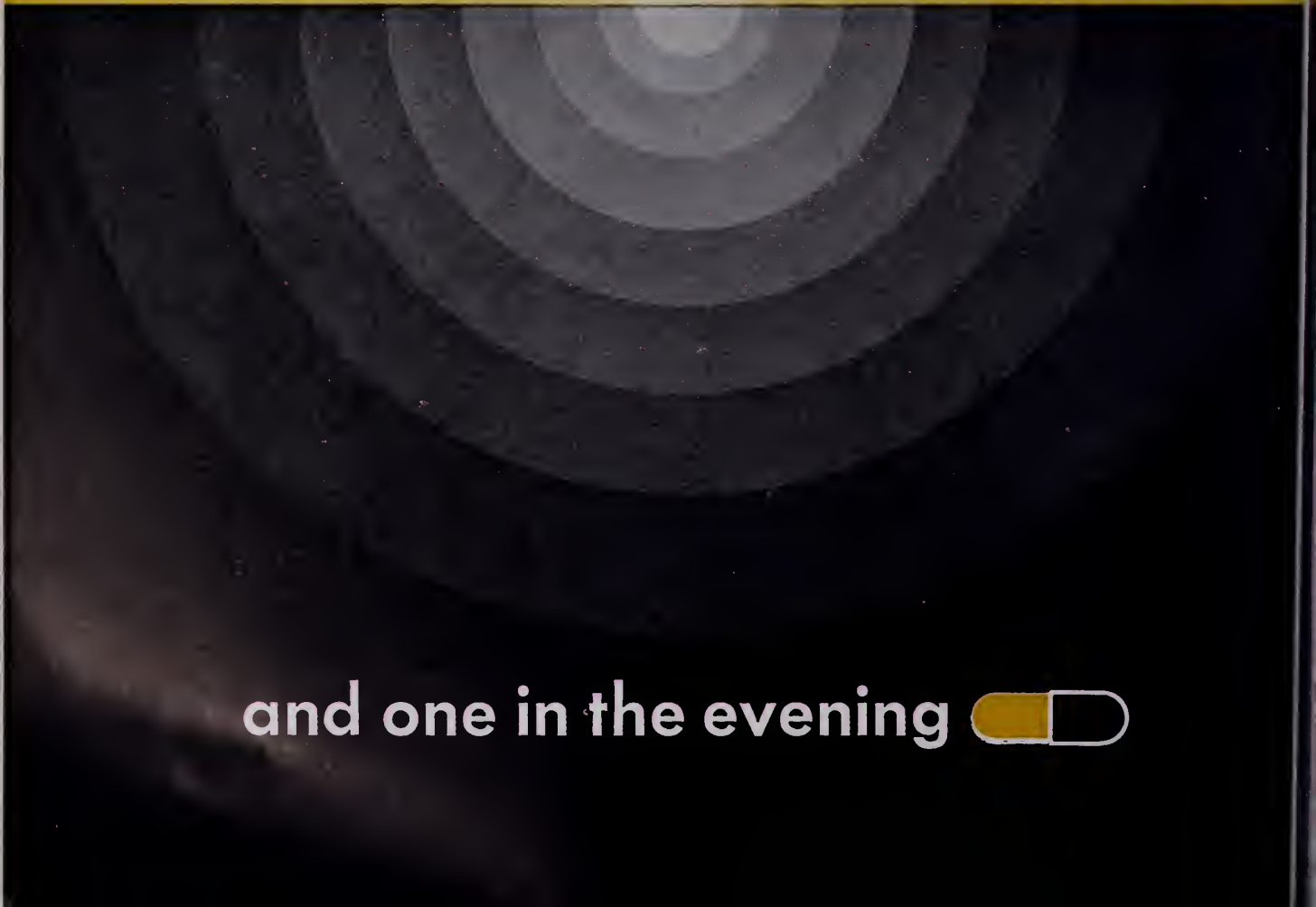
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Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuharic, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

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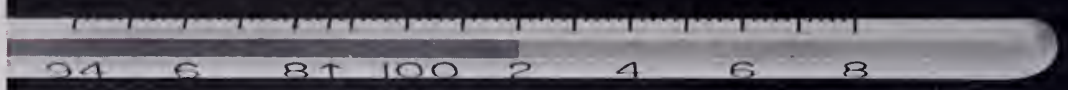
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Mechanical Aids to Respiration: The Use of Intermittent Positive Pressure Breathing (IPPB)†

Hurley L. Motley, M.D.*
Los Angeles, Calif.

Intermittent positive pressure breathing (IPPB) is widely used as a treatment aid in: allergic bronchitis with infection; acute respiratory acidosis; in reducing incidence of post-operative pulmonary complications and obstructive pulmonary emphysema to slow down progression and minimize complications.

INTERMITTENT positive pressure breathing[1], (IPPB), as produced by assistor or automatic type respirators, transmits an increased pressure to the chest during inspiration with active inflation of the lungs, after which cycling occurs with deflation taking place almost to atmospheric pressure as a passive process due to the elasticity of the lungs and chest wall structures. The peak mask pressure varies with the line pressure setting of the apparatus, usually being adjustable up to 30 cm. of water or more on most present day units. When the peak mask pressure is reached, cycling of the respirator interrupts the applied positive pressure and opens the expiratory pathway to atmospheric pressure.

Intermittent positive pressure breathing combined with the simultaneous nebulization of a bronchodilator aerosol, as a specific form of therapy in chronic pulmonary disease, was first used in the treatment of coal miners with emphysema and fibrosis in 1947[2]. Neosynephrine®, a weak bronchodilator, was used in the aerosol, and the clinically observed improvements were impressive even before more potent bronchodilators were employed. The IPPB method of treatment has been found a very helpful procedure for providing subjective relief in many patients having chronic pulmonary ailments with associated fibrosis and/or emphysema. In the patient, severely disabled by emphysema, the clinical response to IPPB treatments may be slow and several months of daily treatments are often required to obtain the maximal response. Some emphysema patients have been rehabilitated sufficiently to carry on their occupation with one or more daily IPPB treatments, when previously, because of the severe dyspnea, they were unable to work. The IPPB treatments do not cure the emphysema, but permit more effective use of the remaining viable lung tissue[3,4]. The positive pressure on inspiration is effective against atelectasis. IPPB when used pre- and post-operatively has been found very helpful in preventing atelectasis in cases with and without respiratory failure.

†*Presented at the Kentucky Medical Association, Louisville, Ky., Sept. 21, 1965.*
**From the Cardio-Respiratory Laboratory, University of Southern California and Hospital of the Good Samaritan Medical Center, Los Angeles, Calif.*

Historical Development of IPPB

The clinical use of intermittent positive pressure breathing devices was studied by the U. S. Air Force as a means of providing more effective artificial respiration in heavy bombers before pressurized aircraft were available[5,6]. The cycling devices were employed to interrupt a continuous positive pressure provided by the pressure demand oxygen regulator to provide an intermittent positive pressure suitable for use in providing effective artificial respiration. The Bennett X-1 and X-2 research model respirators were developed for the Air Force in 1945 for research studies at Aeromedical Laboratory, Wright Field, Ohio[6]. The Bennett X-2 was provided with adjustments to vary inspiratory and expiratory flow rates, inspiratory and expiratory cycling rates and expiratory positive pressure, and with the line pressure setting of the regulator six adjustments were provided which could be made singly or in combination to provide patterns of mask pressures and flows. Studies employing the Bennett X-2 and other IPPB devices with various types of mask pressure curves and the corresponding cardiac output studies (direct Fick) in man resulted in the selection of a type of flow-pressure pattern that most of the IPPB units employ today[7]. The pattern of the mask pressure-flow rate was as follows: a rapid inspiratory flow to the maximal peak pressure, after which cycling occurred with a rapid drop in the mask pressure back to atmospheric pressure, and with expiratory time as long or longer than inspiratory time with no negative pressure on exhalation. The peak flow rate of the unit must provide at all times a flow rate equal to or in slight excess of the patient's inspiratory flow rate, otherwise a negative pressure will result and even though of short interval the patient experiences subjective dyspnea, even on 100% oxygen breathing[8]. The peak inspiratory flow rate of the apparatus should equal at least 75 liters per minute or more. The IPPB apparatus will follow the patient's pattern of breathing, and with a line pressure setting of 15 to 20 cm. of water, most individuals will take a significantly deeper breath than on ambient air breathing. The cycling vane in the Bennett X-2 research model, developed for the Air Forces, continues to be the heart of the present day Bennett respiration units. It was necessary to provide adequate humidification of all the inhaled gas to prevent excessive drying out of secretions[9] for clinical use with the IPPB units, along with the nebulization of bronchodilator substances, antibiotics, wetting agents and other materials.

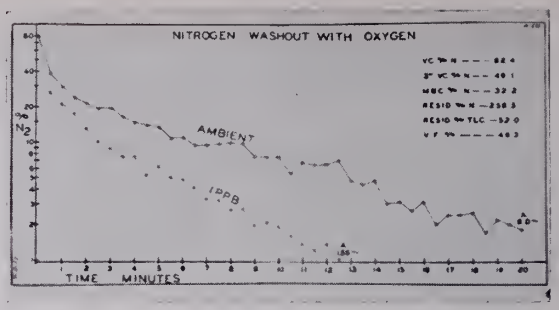


FIG. 1.

The nitrogen washout was obtained on oxygen breathing with a nitrogen meter in a patient with severe emphysema at ambient pressure as shown on the top tracing, and with intermittent positive pressure breathing several hours later in the same patient as shown on the lower tracing. The concentration of nitrogen in the expired air is plotted on the ordinate and the time of breathing in minutes on the abscissa on semilogarithmic paper. The top tracing at ambient pressure reveals that after 20 minutes of oxygen breathing the end tidal nitrogen was 1.8% and the alveolar nitrogen was 8.0%. The bottom tracing reveals that with IPPB the end tital nitrogen was 1.0% after 12.5 minutes of oxygen breathing and the alveolar nitrogen was 1.55%, indicating a very significant improvement in the uniformity of air mixing or distribution of air in the lungs by the IPPB.

Studies in this laboratory have revealed no beneficial effects from increasing the pressure slowly with the IPPB, as applied at the level of the mouth, in the treatment of severe emphysema, with low instantaneous inspiratory flow rates from 30 to 40 liters per minute compared to the best type of mask pressure curve described above with flow rates of 75 liters per minute or more[10]. There was no improvement in the arterial blood oxygen saturation, CO_2 and pH measurements with the slow rate of inspiratory flow with IPPB as compared to the regular rapid type (75 liters per minute or more). Furthermore, in some patients with impaired breathing, the slow rate of inspiratory flow was not tolerated. As described previously, a mechanical assistor device must provide instantaneous flow rate at all times higher than that of the patient, otherwise negative pressure develops with dyspnea. The addition of small negative pressure during exhalation (-6 cm. water) with IPPB pro-

duced no improvement over that obtained with the regular IPPB based on arterial blood studies (arterial blood oxygen saturation, CO_2 and pH)[10], in emphysema patients comparing the two types of flow-pressure curves. Present concepts indicate that the use of negative pressure has no place in the treatment of emphysema, also that the IPPB equipment should be kept as simple as possible for patient's use at home.

Physiological Studies of IPPB

The use of IPPB increases total tidal volume, the effective tidal air volume and the total minute ventilation in most cases of emphysema. The distribution of the inhaled gas is improved with IPPB in patients with impairment in air distribution on ambient breathing[11], (Fig. 1). The increased ventilation blows off the carbon dioxide faster and the improved air distribution results in an increase in the arterial blood oxygen saturation[12], (Fig. 2). Even in patients with severe emphysema, the arterial blood oxygen saturation at rest is significantly improved above that obtained on their own ambient breathing in almost all cases, and in some individuals even up to normal values of 96% or more. Physiological studies indicate that the IPPB increases the arterial blood oxygen saturation by providing a more uniform alveolar aeration of the poorly ventilated or atelectatic areas of the lung, increasing the mean alveolar pO_2, accompanied by a decrease in the mean gradient of oxygen tension from alveoli to arterial blood. By inflating the poorly ventilated or atelectatic alveoli with impaired circulation of air, mechanically obstructed by fibrosis with loss of elasticity and further hampered by edema, secretions and bronchospasm, the alveolar pO_2 is increased as compared to ambient air breathing.

The question has been raised whether the increased alveolar pO_2 with IPPB was not due to replacement of carbon dioxide by oxygen rather than improved alveolar ventilation. Studies have revealed that the mean arterial pCO_2 was not decreased as much as the mean arterial pO_2 was increased. The alveolar pO_2 was not the primary factor involved, but rather the uniformity of alveolar aeration. Studies on coal miner's pneumoconiosis have revealed that the arterial pO_2 was higher with IPPB on compressed air with a calculated mean alveolar pO_2 of 111 mm. Hg. as compared to high oxygen breathing (27.8%) with a mean calculated alveolar pO_2 of 127 mm. Hg., 13 gms. Since the alveolar pO_2 was calculated from the effective inspired pO_2, the arterial pCO_2 and the RQ (respiratory quotient) of the expired air, the changes produced by variations in the carbon dioxide were integrated. The replacement of carbon dioxide by oxygen exerts an insignificant role with respect to the mean oxygen pressure gradient changes with IPPB in chronic pulmonary disease.

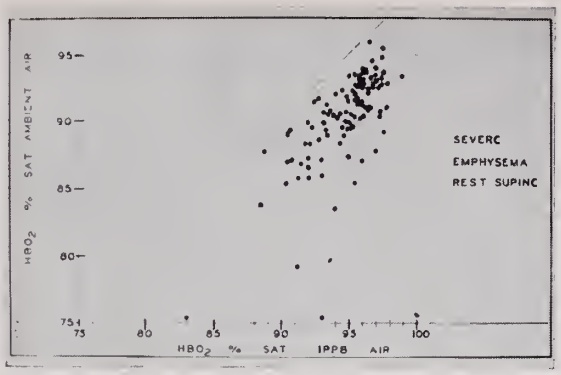


FIG. 2.

The arterial blood oxygen saturation at rest on ambient air breathing in severe emphysema was compared with intermittent positive pressure breathing on compressed air. In every case there was an improvement in the arterial blood oxygen saturation with the IPPB on compressed air only (no bronchodilators or oxygen). In a significant number of cases the arterial blood oxygen saturation was normal, 96% or more on the IPPB on compressed air, and this would indicate the presence of many poorly ventilated areas which could be better ventilated with some assistance on inspiration. The IPPB provides a more uniform distribution of air for the poorly ventilated areas as compared to ambient breathing. Bennett AP-4 used for IPPB.

The severe emphysema patient is often unable to take a deep breath, but with respiratory assistance as provided by the IPPB, the depth of breathing is increased and the poorly ventilated areas of the lung are inflated in a more nearly normal manner. The blood carbon dioxide is decreased during the period of the IPPB breathing on compressed air because of the increased ventilation, and the arterial blood pH increases. The increased elimination of carbon dioxide by the IPPB can be excessive with prolonged use, and this aspect should be checked by arterial pH or CO_2 to prevent the development of significant respiratory alkalosis[14]. However, in the severe emphysema patient, hyperventilation usually is not a significant factor for treatment periods of 15 to 20

minutes, two to four times a day. When IPPB is used continuously by mask or tracheotomy, arterial pH and CO_2 determinations are necessary to prevent hyperventilation even in emphysema cases.

Studies on air distribution in the emphysema patient with the nitrogen meter in this laboratory have revealed that in some cases even 20 minutes of oxygen breathing is an insufficient time to wash out all of the pulmonary nitrogen. The recorded tracings of the nitrogen concentration in the expired air graphically reveal the extensive diffuse involvement with obstruction to ventilation of many alveoli. Secretions are retained in the obstructed areas, with frequent occurrence of secondary infections. The use of pressure breathing promotes bronchial drainage and enables the patient to cough up the secretions. Unless air is present beyond the retained secretions, the cough mechanism is ineffective in raising secretions from such areas. The use of 60% helium and 40% oxygen with the IPPB has proven most useful in distributing the medication more uniformly to the markedly restrictive air passages, which may be almost completely obstructed. Unless air or other gas gets beyond the partially obstructed airways, the patients cannot cough up the material. Helium being a small molecule, and highly diffusible, is valuable in carrying bronchodilators and other medicaments down to the obstructed areas, and at the same time facilitates washing out of CO_2. The value of helium and oxygen with IPPB has been demonstrated by arterial blood measurements of hemoglobin saturation, CO_2 levels and pH in severely ill patients[15]. Studies of arterial blood were made on severely ill patients where the only change in the treatment procedure consisted in changing the IPPB unit from air and 40% oxygen to 60% helium and 40% oxygen. The results of the arterial blood studies before and after the change had been made from four to twenty-four hours revealed improvement in blowing off CO_2 and increasing the pH. The use of 60% helium and 40% oxygen with the IPPB for a few days may prevent the need of a tracheotomy to maintain adequate alveolar aeration in an emphysema patient with pneumonitis or pneumonia. The aerosol from the nebulizer is more effectively distributed with the IPPB in the severe emphysema case with the many poorly ventilated areas, as compared to the patient's own breathing effort, enhancing the usefulness or bronchodilator substances, wetting agents and antibiotics.

An electronic respiration simulator was used to slow the rate of breathing in severe emphysema patients by providing an audible fixed pattern, slowing the rate down to nine to ten per minute. The slower deeper rate of breathing resulted in a significant improvement in the arterial blood oxygen saturation on air breathing and an increased elimination of carbon dioxide during the period of controlled breathing[16]. The total minute ventilation and the resting oxygen uptake were increased slightly. The study indicated that at ambient pressure a slow deep rate of breathing in the patient with severe emphysema was more efficient for blood gas exchange of oxygen and carbon dioxide than a shallow rapid rate. The findings with slow deep breathing, although of smaller magnitude, were similar to the observations with intermittent positive pressure breathing on compressed air.

Treatment Methods

The IPPB may be administered with compressed air, 40% oxygen, or 100% oxygen, in the supine or sitting position. In some cases the use of 40% oxygen and 60% helium is indicated. In many cases, the air compressor type unit is satisfactory for the IPPB as the arterial blood oxygen saturation goes up to 94 to 96% on compressed air only. The use of 40% oxygen is usually adequate for the most severe cases. In the routine treatment of emphysema, pressure settings of 15 to 20 cm. of water are usually used. The pressure setting should be high enough to ensure adequate depth of breathing in the individual case. Patients must be trained to breathe slowly, eight to ten breaths per minute, to obtain the most effective results. Most patients tend to breathe too fast especially at first when put on IPPB, but with training most individuals can attain a satisfactory slow rate, which pattern of breathing is often maintained between the IPPB treatments. Patients should be carefully trained in the proper use of IPPB before they are permitted to obtain a unit for use at home. The use of a mouthpiece is preferable

to a mask on conscious subjects, as the application of the pressure breathing is more direct. Most patients can learn to use the IPPB quite satisfactorily with the mouthpiece and without a nose clip.

Aerosol medications consist of bronchodilators, wetting agents, antibiotics and others. In most cases of emphysema bronchodilators are indicated. The most commonly used potent bronchodilators are Isuprel® (1:200 dilution), Vaponefrin® or Asthmanefrin® for inhalation, Dylephrin®, Aerolene® and others. Isuprel® should be used with caution in cardiac patients. When IPPB is used on compressed air alone, adverse effects of the bronchdilator on the heart should be watched for carefully. Bronchodilators should be used intermittently with IPPB and not continuously. Undesirable cardiac effects (as recorded by the electrocardiogram) may occur on compressed air alone, but be absent when oxygen is used with the IPPB[2]. Neosynephrine (1% solution) is used as a vasoconstrictor for edema, and it can be combined to an advantage with the more potent bronchodilators listed above. Tergemist® and Alevaire® are used as wetting agents. Ethyl alcohol is used with IPPB in the treatment of acute pulmonary edema.

The usual treatment procedure of severe emphysema consists of six to eight drops of bronchodilator mixed with 10 to 30 drops or more of water in the nebulizer. Tergemist® or Alevaire® may also be used in the nebulizer with a corresponding reduction in the amount of water. The needle valve controlling the rate of nebulization should be adjusted so that at least 15 minutes are required to completely nebulize the total quantity of fluid in the small nebulizer (additional water or wetting agents may be added to increase the dilution if necessary). Antibiotics can be added to the above solution if indicated. Antibiotics commonly used and the dosage include Tetracycline (50 mg.), Penicillin (500,000 units) Streptomycin (50 mg.), Neomycin (25 to 50 mg.), and others.

Drying out of secretions may become a problem with long continued use of the IPPB, as the humidification provided by the small nebulizer is inadequate to prevent drying out of secretions. The IPPB units should be equipped for mainstream type nebulization to provide adequate humidification. The recent-

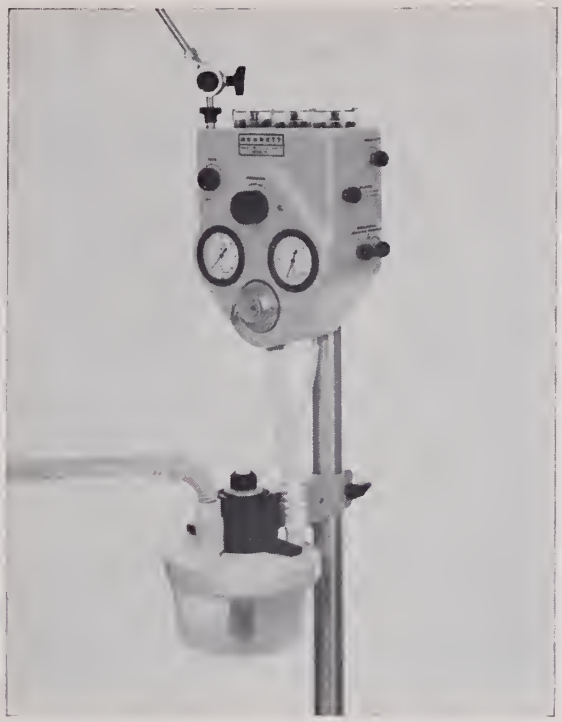


FIG. 3.

The Bennett Automatic Hospital Unit (PR-1), equipped with the Cascade type mainstream humidifier.

ly introduced cascade humidifier on the Bennett units (Fig. 3) is most effective. Humidification may be at room temperature or as a tepid mist at 37° centigrade. The tepid mist should be tried in the presence of throat irritation. The mainstream type units prevent air or air and oxygen or helium mixtures with the IPPB units from drying out of secretions especially when used for long periods continuously as with a tracheotomy tube. Effective humidification is particularly helpful for patients who have thick tenacious secretion and the raising of sputum is facilitated. Tergemist® or Alevaire® may be used in the large mainstream humidifier, however water alone is probably the best substance to use.

Chronic Pulmonary Emphysema

In the treatment of chronic obstructive pulmonary emphysema the primary value of IPPB is to try to prevent any further progression in the severity of the emphysema and to minimize complications. If an accurate diagnosis of severe emphysema has been made from pulmonary function studies, such a patient should benefit from the routine use of

intermittent positive pressure breathing therapy at home. Emphysema as used in this paper is an irreversible condition with the air spaces distal to the terminal bronchioles enlarged from destruction of alveolar walls. Three or more treatments of 15 to 20 minutes duration in the sitting position with a suitable bronchodilator should be taken every day for an indefinite period. It is most important that bronchospasm be controlled as completely as possible. The primary function of the pressure breathing is to try to keep open and clean the airways and control bronchospasm, an important factor in preventing progression of the emphysema. When the absolute volume of the residual air is markedly increased (above 200% of predicted) every effort should be made to try to prevent further progression in this abnormality. Smoking is completely contraindicated. If the patient continues to smoke this may more than offset all the benefits that can be obtained with the IPPB and bronchodilator treatments. In most patients the progression of the emphysema can be slowed down or halted with the proper use of IPPB along with other therapy as indicated. The net result is more adequate function of the bronchiolar airways, and the more effective functioning of what good lung tissue remains. Living becomes more comfortable and some individuals have been able to return to work. The IPPB will not cure the emphysema that is already present, but every effort should be made to try to prevent progression, for once the progression has occurred the destruction of lung parenchyma is permanent and there is no reversal.

Repeated treatments, three or more times daily for 15 to 20 minutes each during a two to three week period, have been found to promote bronchial drainage. Mucus and secretions are not washed further down the respiratory tract by IPPB, as the peak expiratory flow velocity is greater than the peak inspiratory velocity and the net result is to work secretions outward, an expectorant-like action. A cough raises secretions by a similar air flow velocity mechanism. Improved bronchial drainage has been a consistent finding with treatment in patients having increased amounts of sputum and in patients having thick tenacious secretions difficult to expectorate. One or two months or sometimes more may be required for the beneficial effects to be manifest subjectively in severely dyspneic and emphysematous patients when treatments are being taken daily at home. A much greater improvement in breathing may be noted after a course of treatments as compared to a single treatment evaluation by spirometric measurements. However, the failure to demonstrate any significant improvement by spirometric measurements after one treatment with a bronchodilator does not mean that the patient may not show considerable improvement after several weeks of therapy.

The basic principle of treatment in emphysema is to provide an effective or adequate bronchiolar airway. Ventilation through the airways may be obstructed by atelectasis, bronchospasm, edema of the wall, infection and retained secretions. The slight positive pressure on inspiration helps carry the medication down to the obstructed air passages, beyond the secretions and mucus plugs into the terminal air passages where the most good can be accomplished. The elimination of retained secretions is an important problem in the treatment of emphysema, and this can be helped by liquifying the secretions by the liberal use of fluid, preferably by mouth, but if necessary parenterally. The use of the 60% helium and 40% oxygen with the IPPB is most useful in many cases in distributing more uniformly the medication down to the markedly restricted air passages. The helium and oxygen is used for the first ten minutes and air and oxygen the second ten minutes for each IPPB treatment when given three or four times a day. If the patient does not raise his secretions assistance may be provided by using a catheter and actually sucking out the secretions from the trachea and major bronchi. We have found the Bennett model PR-1A respiration unit (Fig. 3) most useful in treating severe infections in emphysema cases requiring respiratory assistance for several days in order to provide adequate alveolar aeration. Since the automatic unit has been available it has not been necessary to put emphysema patients in the iron lung, a big help from the standpoint of care of the patients and decreased costs of the hospital care.

The following case illustrates the use of IPPB as one of the treatment procedures

over a 15 year period without progression in the severity of the emphysema. This patient was 44 years of age at the time of the first pulmonary function study and complained of severe dyspnea. The dyspnea had been slowly progressive for the past several years. He had a past history of tuberculosis which had been treated with pneumothorax and rest with a reversion of the sputum to negative. The sputum had been negative for the past 12 years. The X-rays revealed moderately far advanced bilateral pulmonary tuberculosis of long standing. The lower lung fields were hyperaerated and the diaphragmatic motion was limited. Pulmonary function studies revealed a marked reduction in total vital capacity (38% of predicted), a marked prolongation of the rapid forced exhalation with a forced expiratory volume for three seconds of only 22.4% of the predicted, a maximal breathing capacity of only 19.4% of predicted (increased to 30.2% after a bronchodilator treatment with Isuprel®). The absolute volume of the residual air was 194% of predicted (almost twice normal), and the ratio of residual air to total lung capacity was 63.0% (a marked increase). The total lung capacity was 77% of predicted, a decrease in spite of the marked increase in the absolute volume of the residual air, indicating the presence of a restrictive element, in this case fibrosis. The resting arterial blood oxygen saturation was 92.8% and with mild exercise there was a drop down to 81.5%. The exercise oxygen uptake was only 354 ml. per minute per square meter body surface area (normal value 500 to 600), indicating the inability to increase the pulmonary blood flow corresponding to the degree of exercise given. The studies indicated the presence of significant cor pulmonale. Follow-up studies were obtained in 1954, 1960, 1962 and in 1966. The residual air was 56.6% of the total lung capacity in 1966 as compared to 63.0% in 1951. The resting saturation in 1966 was 90.5% as compared to 92.8% in 1951. The alveolar nitrogen was 8.09% in 1951 and 5.9% in 1966. In 1951 this patient was started on intermittent positive pressure breathing at home three times a day with each treatment of 15 to 20 minutes duration. The IPPB treatments have been continued up to the present time. Asthmanefrin® and Isuprel® were used for bronchodilators with the IPPB. The follow-up pulmonary function studies demonstrate that the progression of the emphysema can be halted in some cases even over a long period of time with active treatment.

Allergic Bronchitis with Infection

Allergic bronchitis with infection can simulate severe obstructive pulmonary emphysema if pulmonary function studies are made in the presence of bronchospasm, infection and retained secretions. Allergic bronchitis is a quite common condition and fortunately responds very well to IPPB therapy along with other treatment as indicated, however if this condition is not recognized and adequately treated, especially the bronchospasm, emphysema can develop. The bronchospasm may be resistant to treatment in some cases. In addition to bronchodilators and the IPPB, these patients need appropriate antibiotics, adequate humidification of the inspired air, adequate hydration, expectorants such as potassium chloride or potassium iodide and in some cases steroids for more persistent bronchospasm. After the condition clears up the patient may or may not require daily IPPB treatments. In some cases the bronchospasm can only be controlled with the use of steroids, and if this is necessary it should not be withheld from the patient. Uncontrolled bronchospasm appears to be a most significant factor in the development of emphysema.

A patient with allergic bronchitis is illustrated below. This man had a past history of asthma from age three to ten after which he had no further asthma until recurrence at age 22 associated with an infection in the chest. The bronchospasm was controlled at first with the use of a hand nebulizer with Isuprel®. He had an emergency appendectomy and this was followed by severe dyspnea postoperatively, accompanied by wheezing, cough and a muco-purulent sputum. Attempts at desensitization were unsuccessful. The condition persisted for over three months and did not clear, and it was still present at the time of the pulmonary function studies. At the time of the first study there was an increase in the antero-posterior diameter of the chest, hyperresonant lungs, distant breath sounds and some scattered rhonchi with generalized wheezing

on prolonged expiration. The vital capacity was 58% of predicted. There was a marked prolongation of the rapid forced exhalation indicating airways obstruction. The maximal breathing capacity was 35% of predicted. A slight degree of bronchospasm was demonstrated. The residual air was 182% of predicted and 44% of total lung capacity. Intrapulmonary mixing was severely impaired by the nitrogen washout with the nitrogen meter. The arterial saturation was 87.7% at rest and 81.8% with mild exercise. The CO_2 content was normal both at rest and with exercise. The X-rays revealed overexpanded lungs with multiple densities in the upper one-half bilaterally. The diaphragm was low and flat. Sputum studies were negative for acid fast organisms. A scalene node biopsy was negative. Bronchoscopy revealed thick viscid purulent secretions. The sputum contained cylindrical, branching casts up to four millimeters in diameter and four centimeters long. Eosinophiles and mucinous material were present on the microscopic sections. The patient was treated with intermittent positive pressure breathing with Isuprel® and wetting agents, systemic antibiotics, intravenous aminophylline and expectorants. No significant improvement was obtained until prednisone was added to the treatment and then the bronchospasm disappeared after 48 hours and the sputum cleared. Follow up function studies after treatment revealed a vital capacity of 90% of predicted, only a slight prolongation of the rapid forced exhalation and a maximal breathing capacity 78% of predicted. Bronchospasm was still present in a slight to moderate degree. The residual air was 144% of predicted and 29% of total lung capacity. Intrapulmonary mixing was still abnormal although improved after the treatment. The arterial blood oxygen saturation was 94.9% both at rest and with exercise, a marked improvement after treatment. The follow up pulmonary function studies revealed marked improvement after treatment, but all the measurements were not normal. This patient has required in addition to daily IPPB and bronchodilator treatments a dose of prednisone of at least ten mg. daily to prevent recurrence. In addition expectorants and rectal theophylline were used. Regular clinical examinations for the past eight years have revealed a continuing asymptomatic state on the above routine, but neither the IPPB nor prednisone can be omitted without return of symptoms. He is no longer short of breath and is able to work every day as a tractor operator.

The above case indicates what can be accomplished with adequate treatment of an allergic bronchitis with infection, in this case a patient with symptoms persisting unrelentingly for three months. If this condition had been allowed to persist with the overdistention which was present in the lungs as revealed by the first pulmonary function studies, I don't think there is any doubt that severe irreversible emphysema would have developed. This is the type of patient where real good can be accomplished by adequate treatment. The intermittent positive pressure breathing is indispensable in maintaining this man on the job every day along with the other medication. It is the combination of treatment procedures rather than any one single factor. The bronchospasm must be controlled, the infection treated and secretions removed in order to keep the airways open and clean so that the normal function of gas exchange can occur adequately both at rest and with exercise.

Respiratory Acidosis

Some patients with severe emphysema and hypoxia on oxygen breathing at ambient pressure do not ventilate the alveoli enough to blow off the carbon dioxide as fast as it is formed. Hypoxia is relieved by oxygen breathing and part of the respiratory reflex stimulation from the carotid body by the low oxygen tension is removed and there is less reflex stimulation of respiration. The carbon dioxide increase from retention in the blood does not stimulate the respiratory center normally in such cases, and the pH decreases with associated mental changes. Coma often occurs in acute respiratory acidosis, and the diagnosis has frequently been mistaken for coronary occlusion, cerebral vascular accident or brain tumor. It is probable that many patients have died from unrecognized acute respiratory acidosis. Diagnosis has to be made during life, and an arterial blood pH determination is the easiest and simplest procedure for an accurate appraisal. The pathologist cannot make a diagnosis of acidosis at the postmortem examination, as there are no characteristic findings. The emphysema patient with a pneumonia or pneumonitis is a good candidate to develop

acidosis especially on oxygen breathing. The condition is aggravated or even may be precipitated by the use of barbiturates or the opiate group of drugs which depress the respiratory center still more. Inadequate alveolar ventilation permits respiratory acidosis as a result of retained carbon dioxide. It has been observed that some severe emphysema patients on oxygen breathing, even for as short a period of time as six to ten minutes, may have a pH decrease of 7.42 to 7.35 (early acidosis)[17]. Such a patient may become sleepy. Some patients may take several hours or even a day or more for the pH to drop to a significant level with the development of mental symptoms (irritation, nervousness, restlessness, drowsiness, stupor or coma). It should also be noted that many cases will never develop acidosis even on prolonged oxygen breathing by nasal cannula or mask at ambient pressures. Oxygen is often necessary and should not be withheld from the cyanotic patient who is seriously ill, as oxygen can be given safely when combined with some respiratory assistance such as IPPB. The arterial blood pH should be carefully followed to nized and the possibility of respiratory acidosis kept in mind.

Protection Against Atelectasis

Clinical observations were made in 1946 with IPPB on nine patients convalescing from thoracoplasties and lobectomies[1]. No adverse effects occurred from the use of IPPB from 15-20 minutes with a line pressure setting of 21 cm. of water. The purpose of the IPPB was to expand more fully the lungs and protect against atelectasis. Fluoroscopic observations made on six cases with the IPPB demonstrated an improvement in the expansion of the lung on the operated side.

Noehren et al.[19] reported IPPB as a major contribution in the prevention and treatment of postoperative pulmonary complications. Jones and Meyers[20] use IPPB routinely pre- and postoperatively on all chest surgery cases. The use of IPPB before surgery trains the subject to be familiar with the apparatus as well as to improve the airways and alveolar ventilation in many cases. Jones and Meyers[20] report a clinical reduced incidence postoperatively of atelectasis. Anderson et al.[21] reguard against the presence of respiratory acidosis, so corrective treatment can be provided to improve alveolar aeration.[18]

An elderly patient with severe pulmonary emphysema with a major fracture is a candidate for acute respiratory acidosis in the presence of a respiratory infection or pneumonitis. After two or three weeks with the fracture immobilized in a cast, the patient develops a respiratory infection, and because of the clinical presence of some cyanosis, oxygen is given by nasal cannula or mask. The oxygen administration results in nervous symptoms such as restlessness, and this is followed by a sedative, such as a barbiturate, and then a coma develops. An arterial blood pH reveals the difficulty (respiratory acidosis). Intermittent positive pressure breathing with 60% helium and 40% oxygen may restore consciousness in such a patient in one to two hours without further difficulty. The principle of the treatment here is to increase alveolar ventilation, stop the sedation and give the oxygen with respiratory assistance. If such a patient died the pathologist would find pneumonia as the cause of death. The treatment is easy if the setup for the condition is recogported significant postoperative complications in 19.5% of their control group as compared to 2.5% of the IPPB treated group.

Contraindications

In the presence of massive hemorrhage, IPPB should be withheld. Hemorrhage may occur in some patients spontaneously, but if this occurs while they are on IPPB, the procedure may be blamed for the occurrence. In many cases, after the hemorrhage has subsided, patients have been returned to IPPB without difficulty. Many physicians regard active pulmonary tuberculosis as a contraindication, while others feel IPPB can be used in selected cases with caution[22]. Large bullae or cysts in the lungs may increase in size in a rare case, but in most cases IPPB can be given without any change in the size of the cyst or cysts. If venous return is markedly impaired, the line pressure should be decreased or the IPPB discontinued. This condition can usually be detected satisfactorily by palpation of the radial pulse.

IPPB is contraindicated in the presence of hyperventilation, or in patients in whom the

respiratory assistance markedly lowers the pCO_2 or elevates the pH in a marked degree. The hyperventilation may result in anginal-like pain in some cases. The direct measurement of the arterial pH or arterial pCO_2 will prevent this error in management of the individual case. I am sure some of the IPPB treatment failures reported have included the hyperventilation problem that was not recognized clinically. A moderate amount of hyperventilation is tolerated without difficulty in emphysema patients for three or four treatments a day for 15 to 20 minutes.

Probably the greatest single hazard for IPPB is inadequate or improper instruction and supervision by individuals giving the treatment to the patient. Certainly many treatment failures have resulted from inadequate administration. The Inhalation Therapist should make every effort to give the IPPB treatments in an effective manner. Patients who obtain an IPPB unit for use at home should receive adequate instruction in the use of the apparatus from the Inhalation Therapist or physician before the unit is delivered to their home. If the physician doubts the value of IPPB, then I feel this modality of treatment should not be used in the management of his patients.

Equipment

Most of the present day commercial IPPB equipment can be used satisfactorily in treating chronic pulmonary disease. It is desirable for home use to keep the equipment as simple and foolproof as possible. Service should be readily available for the IPPB apparatus in the area locally. Inhalation Therapists and hospital personnel should be thoroughly familar with the equipment used in the hospital, so that satisfactory performance at all times will be insured. Scrupulous care in sterilization to prevent cross contamination in hospital and clinics is required at all times for the manifold, tubing, nebulizers and humidifiers. The pressure breathing equipment most commonly used in the United States at the present time include: Bennett, Bird, Emerson, Dotco, Mines Safety and Monaghan.

Summary

Something can be done in many cases of severe pulmonary emphysema with active therapy in preventing progression of the condition which tends to occur if nothing is done. The emphysema cannot be cured, but every effort should be made to try to prevent progression. This is particularly true for bronchospasm and the absolute volume of the residual air which may be over 400% of the predicted in some cases. In the treatment of emphysema if progression is to be prevented, the patient must have an IPPB unit for use at home, where two, three or four 15-20 minute treatments can be taken every day. This is the only way to obtain the maximal benefits possible. A course of treatments of 10 to 14 days in a hospital does no good in preventing progression, except in the presence of acute infections with pneumonitis or pneumonia. Emphysema is a chronic disease and the treatment has to be continued indefinitely. Cigarette smoking is contraindicated, and if smoking is continued this may more than offset all the good accomplished by treatment.

Treatment of allergic bronchitis is directed against the bronchospasm, infection and retained secretions. In resistant cases the bronchitis may exist for several months uncontrolled, and resistant to usual desensitizing procedures. The intensive use of IPPB with bronchodilators, suitable antibiotics, expectorants and aminophylline may be adequate. In some cases steroids are required in addition to control the bronchospasm. Some patients require continuous treatment with IPPB, bronchodilators, aminophylline and steroids to maintain asymptomatic state without recurrences.

Respiratory acidosis develops because of alveolar hypoventilation, as carbon dioxide is not blown off by the lungs as rapidly as formed by body metabolism. The severe emphysema patient with a pneumonits or pneumonia is a good candidate to develop acute respiratory acidosis especially on oxygen breathing or even after sedation with opiates or barbiturates. The diagnosis may be mistaken for coronary occlusion, cerebrovascular accident, or brain tumor. An arterial blood pH takes the guesswork out of the diagnosis. Respiratory assistance with IPPB is often necessary to maintain adequate elimination of the CO_2 especially with oxygen administration. Oxygen is necessary in most cases and should not be withheld since safe administration is easy with IPPB.

The use of intermittent positive pressure breathing pre- and postoperatively is helpful

in reducing the incidence of postoperative pulmonary complications, particularly atelectasis. It has been recommended for all patients undergoing thoracic or abdominal surgery, since the possible reduction in postoperative morbidity and decreased hospital days adequately justifies such a routine.

The successful application of IPPB therapy depends on a planned coordinated treatment program. There is almost no clinical problem in which the use of IPPB therapy alone will achieve total success, and to employ it with such expectations would lead to frustrations and will also create a false impression of ineffectivenes[23].

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A Case of the Trisomy 17-18 Syndrome With Tracheo-Esophageal Fistula†

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A newborn female infant with a specific array of congenital anomalies was studied for the possibility of a specific chromosomal abnormality. The patient also had an anomaly rarely associated with the chromosomal trisomy.

A SYNDROME of multiple congenital malformations associated with trisomy (triplication) of a chromosome of the 17-18 group (or group E) was first described by Edwards et al[1] in 1960. Since that first instance over 50 similar cases have been reported. This disease is now felt to be a fairly uniform syndrome associated with a specific chromosomal abnormality. The present case is being reported because of the usual associtaion with a tracheo-esophageal fistula.

Case Report

D. S., a one-day-old white female infant, was admitted to the University Medical Center because of multiple congenital anomalies. The patient was born to a normal 26 year-old gravida IV, para. IV woman after a 40 week gestation. The pregnancy was complicated by bleeding in the first trimester and a sudden increase in weight in the 38-to-40th week. The infant was born with vertex presentation and had an Apgar score of 4 at 1 min. and 8 at 5 min. (The Apgar score is a system of grading the responses of the newborn infant in the first few minutes of life, including respiration, heartbeat, oxygenation as determined by skin color, muscle tone, and response to painful stimuli.



FIGURE 1A: Facies of infant D.S. showing a small fish-mouth.



FIGURE 1B: Profile showing small low-set ear, prominent occiput, and micrognathia.

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FIGURE 1C: Hand showing characteristic flexion of the index and fifth fingers over the third and fourth fingers.

Each of these five characters is graded from 0 to 2 with a total score possible of 0-10 with a normally active infant scoring between 8 and 10.) The birth weight was 1990 gms. The father (age 28) and the three older siblings are normal.

Physical Examination

The patient was a small, abnormal appearing infant with respiratory distress and mild cynanosis. She had a small fish-like mouth (Figure 1A), an occipital protuberance and small low-set ears (Figure 1B). The head circumference was 31 cm. (12¼″). Micrognathia (Figure 1B) and a high arched palate were also present. The neck was short and the chest had a shield-like shape with a short sterum, widely spaced nipples and a prominent precordium. Auscultation of the chest revealed bilateral rales and rhonchi in both basis, regular cardiac rhythm and a short systolic murmur over the pulmonic area. The spleen was just palpable and there was just one umbilical artery in the umbilical stump. The hands were in the characteristic position for trisomy 17-18, with the second and fifth fingers flexed over the third and fourth (Figure 1C), and rocker bottom feet were present (Figure 1D).

Laboratory Data

Laboratory studies included: Hb. 18.5, Hct 57, BUN 18, Bilirubin 15. (Conjugated 2.5). On the third day the bilirubin rose to 19.8 (conjugated 5.). The EKG and IVP were normal. A chest X-ray showed tracheo-esophageal fistula (TEF) type III and possible enlarged



FIGURE 1D: Foot showing plano-convex sole and posterior protrusion of heel (rocker-bottom foot)

heart with increased pulmonary vascular markings.

Chromosomal Analysis

Culture of peripheral leucocytes from a blood sample was attempted when the patient was one day old, but there was no growth. Culture was repeated at the age of 11 days and was successful. Thirty cells were counted and 29 (97%) had 47 chromosomes. The remaining cell had 46 chromosomes and was considered to be a broken cell. Karyotypes of 2 cells showed trisomy of a chromosome of group 17-18 (Figure 2). The parents and siblings were not available for chromosomal study.

Hospital Course

The patient was in severe respiratory distress on the first hospital day. After four hours, she had a gastrostomy under local anesthesia for relief of the TEF. During the second hospital day, the patient had ligation of the fistulous tract using a transthoracic approach. She developed jaundice on the second day, which deepened on the third day, and on the fourth day an exchange transfusion was done Throughout her course she did poorly. On the fourth day she required a mechanical respirator which was continued intermittently until her death. She also required gastrostomy feedings throughout

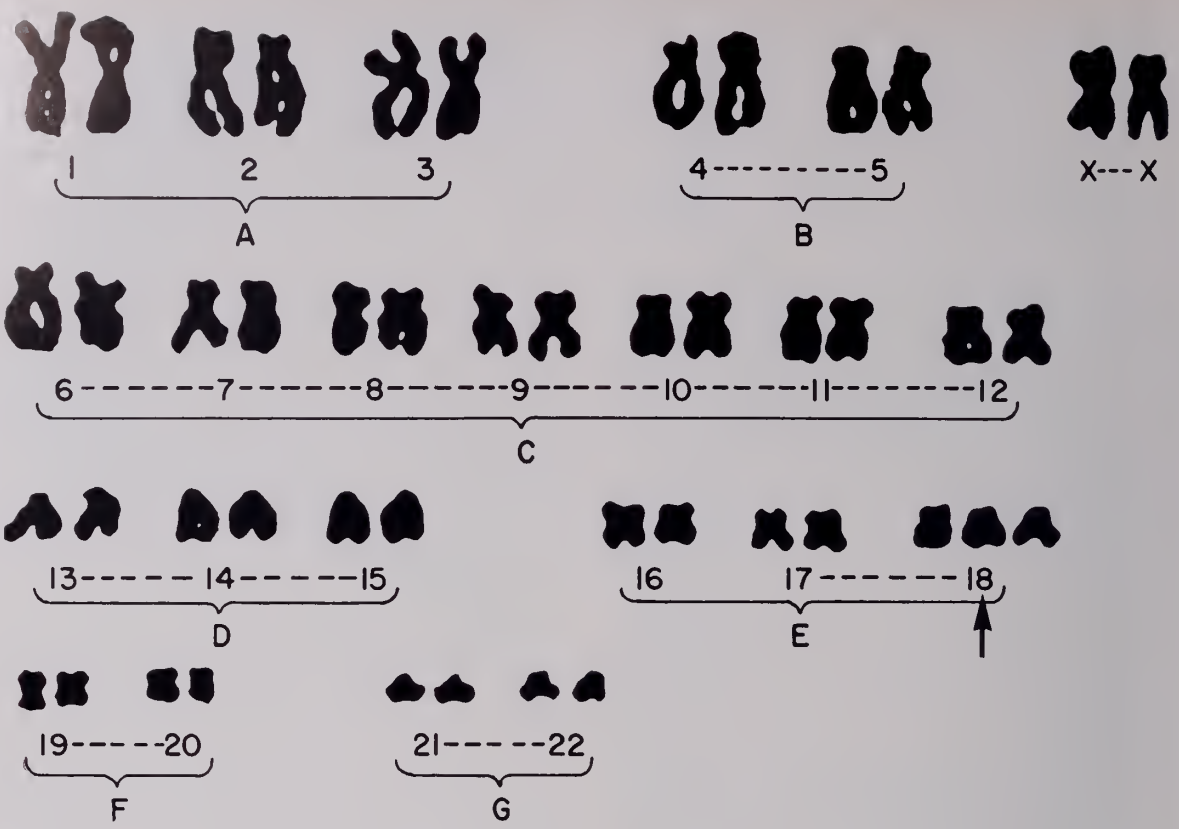


FIGURE 2: Karotype of one cell showing trisomy (triplication) of a number 17-18 (group E) chromosome (arrow). The dotted lines connecting most of the numbers indicate that these chromosomes cannot be positively identified by exact number and are usually grouped by letter also. Many investigators place the X chromosome with group C.

life. On 7/29/65 she developed bradycardia and on 8/7/65 (16th day) she died.

Post Mortem Examination

The autopsy revealed the following: normal brain, malformed ears, mild Pierre-Robin Syndrome, high arched palate, enlarged heart (RVH), membranous ventricular septal defect, patent ductus arteriosis, probe patent foramen ovale, high origin of right coronary artery, redundancy of the leaflets of the aortic valve, bicuspid aortic valve, acute intersitial pneumonitis, tracheo-esophageal fistula type III, thymic atrophy, acute hepatic and splenic congestion, acute adrenal congestion, Meckel's diverticulum, horseshoe kidney, urachal cyst, and a single umbilical artery.

Discussion

The clinical, pathological and chromosomal abnormalities associated with the trisomy 17-18 syndrome have been discussed in great detail by several authors.[2-5] Prenatally the syndrome is characterized by an increased maternal age, hydramnios and decreased and feeble fetal movements. The natal period is usually associated with small placenta and low birth weight (intra uterine growth retardation). About 90% of the cases described have been Caucasians. The frequency of trisomy 17-18 is roughly estimated at one case per 600 to 800 live births, and it occurs three times as frequently in females as males.[5] In the neonatal period there is failure to thrive and early death (3-4 months).

The infants are apparently severly mentally retarded with hypotonicity at birth followed by hypertonicity and spasticity. The pertinent physical abnormalities include: a prominent occuput, low set malformed ears, micrognathia, small triangular mouth, high arched palate, short sternum, umbilical and inguinal herniae, flexed overlapping fingers, and rocker-bottom feet (convex soles and one or more centimeter posterior extension of the heel).

On pathologic examination, the following are usually found: a small underdeveloped brain, congenital heart disease (ventricular septal defect, patent ductus arteriosus, patent foramen ovale, coarctation of the aorta, or valvular anomalies), duplication of the ureter or kidneys, horseshoe kidney, absent or small muscle fibers and altered bony development from decreased muscular stress.

Abnormalities of the gastro-intestinal tract include most commonly Meckel's diverticulum and ectopic pancreatic tissue. Other more rare gastro-intestinal anomalies in the trisomy 17-18 syndrome include malrotation, diaphragmatic hernia, accessory spleen, giant cell hepatitis[1] and extrahepatic biliary atresia,[6-7]. Tracheo-esophageal fistula has been described only twice before in this syndrome[8-9]. One is described as being of the H-type[8] while the type in the other case is not ascertained.[9]

Summary

A case of multiple congenital anomalies in a Caucasian female is presented. The physical examination, autopsy and chromosomal findings are consistent with trisomy 17-18 syndrome. This case is one of three reported cases of this syndrome with tracheo-esophageal fistula.

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Epidemiological Aspects of Toxoplasmosis

Munevver Bertan, M.D.,* and Shelly E. Bennett**

Lexington, Ky.

The prevalence of toxoplasma infection varies considerably among normal populations in different parts of the world. Some of the epidemiological aspects of toxoplasmosis, particularly as studied in Kentucky, are presented in this paper.

Toxoplasmosis is a highly prevalent disease the world over. However, the frequency of infection varies markedly in different areas with warm, moist areas having higher rates than cold, dry ones. Several frequency distributions of toxoplasma antibodies in various population groups have been reported: 4% in Guatemalas, 0 in Eskimos, 4% in Navajo Indians, 34% in Pittsburgh, Pennsylvania, 64% in Honduras and Tahiti[1].

Infection Rates

In a nationwide serum survey of United States Military recruits carried out in 1962[2], 14% of the recruits were found to have a significant titer of toxoplasma dye-test antibodies.* Those recruits coming from the western part of the United States had a significantly lower infection rate than the average. Infection rates were essentially similar in urban and rural areas. Kentucky recruits showed a 20 to 25% rate of infection which was above the recruit average of 14%. There is additional evidence that the disease is not uncommon in Kentucky. Seventy-three serum samples tested in the State Health Department laboratory during the last five years (September, 1959-January, 1965) have had a titer greater than 1/64 with the Sabin-Feldman dye test. Several active cases have also been reported from Pikeville, Kentucky.[3]

The Department of Community Medicine, University of Kentucky, School of Medicine studied the prevalence of toxoplasmosis in Leslie County.[4] The total population of Hyden, in Leslie County, was skin tested and serologic samples were taken. The skin test results revealed 38% of the population to be positive. There was no significant difference between male and female rates although the infection rate did show an increment with increasing age.

Toxoplasmosis is known to infect a variety of species of mammals, birds and reptiles.[5] Prevalence data from previous studies in the U.S.A. and overseas have reported infection rates in dogs and cats to be between 5 and 60%[6,7], in cattle 50%[7], and in pigs 15 to 40%.[8] Both livestock and pets need to be studied in Kentucky to uncover just how prevalent the disease is among our animals.

The organism, toxoplasma gondi, is a protozoan. It is delicate, has an oval or crescent-like shape, measures 2 to 4 x 4 x 7 microns in the proliferate form. Multiplication has been noted only in the presence of living cells. The proliferate form is considered to be sensitive to changes in osmotic pressure, drying and exposure to artificial gastric juices. This form dies rapidly as soon as it leaves the animal host. In chronic infections, toxoplasma occurs in an encysted form. This cyst form appears to be more resistant to environmental influences and possibly plays a major role in the transmission of infection.

Transmission

The mode of transmission of toxoplasmosis is not yet known. The fact that the infection is so widespread may indicate that it is transmitted in some simple fashion. Rodents can be infected experimentally by ingestion of the toxoplasma organism. The cyst form has been found in muscle tissue of both pigs and cattle. Therefore the possibility arises of human infection being caused by ingestion, possibly raw meat. Evidence which supports this hypothesis is a high titer prevalence of toxoplasma anti-

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bodies (over 1:64) among patients with cases of trichinosis.[10] However, vegetarians also show evidence of toxoplasma infection.[11] In addition, although Tahiti and the Caribbean region populations have very high rates of infection, meat is rarely eaten in Tahiti and when eaten in the Caribbean it is very well cooked.

The only documented form of man-to-man transmission has been in utero from mother to unborn fetus. Gibson, et al.,[9] using one infant born with congenital toxoplasmosis as an index case, studied the prevalence of animal infections in the surrounding area. Cats, pigeons, mice and ducks were all found to have a positive serology.

Epidemiologic study is needed to test the usual modes of transmission, such as ingestion, inhalation, trans-placental, and transmission by vectors.

Despite the vast amount of infection as indicated by serologic evidence the clinical syndrome is quite rare. Congential toxoplasmosis has a reasonably well documented group of clinical manifestations such as microcephaly, jaundice, hepato-splenomegaly, skin rashes, chorioretinitis, convulsions and cerebral calcifications. Usually infection after the first year of life passes unrecognized. Sometimes, toxoplasmosis may be clinically manifested as lymphadenopathy and cases diagnosed as "glandular fever" may actually be due to toxoplasmosis.[12] Acquired toxoplasma infections may also affect other organ systems, simulating myocarditis, pneumonitis, or encephalomyelitis.[1,14]

Laboratory Detection

The best laboratory method for confirming a clinical impression or the presence of an asymptomatic infection of toxoplasmosis is serology. Techniques available are the Sabin-Feldman dye test, complement fixation, and hemagglutination tests. Fluorescent antibody methods have also been used. At the present time the State Health Department laboratory will process serologic specimens. Thus far the Sabin-Feldman dye test is the most reliable method; however, some cross reactions in very low titer (1:4) are known to occur with sarcocysts and trichomonas vaginalis infections.[15]

A toxoplasmin skin test is available for surveys. In one study a positive correlation was found between the skin test and the dye test which was as high as 82%.[13] Yet definitive diagnosis depends on isolation of the causative organism. To date this has been accomplished only by intraperitoneal inoculation of biopsy materials (brain or muscle tissue) in mice free of toxoplasma infection.

An infection as ubiquitous as toxoplasmosis obviously needs further epidemiologic study which will help to show the interrelationship of animal and human infection. This approach is of prime importance since such heavy prevalence of infection concurrently in both man and animals may point to the possibility of a zoonotic disease. The hypothesis suggesting the transmission of the disease via the ingestion of meat or other food merits further investigation.

Several studies have demonstrated that a higher percentage of persons are serologically positive in older age groups than in younger areas.[7] Prospective studies will be very helpful to elucidate the reasons for such serologic conversion in older ages.

Physicians in an endemic area like Kentucky should have a high index of suspicion for this disease since the clinical manifestations are so varied. Blood samples may be sent to the State Health Department laboratory for confirmation of any suspected cases.

*over 1-16 titer

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SPECIAL ARTICLES

Action and Reaction†

IRVING F. KANNER, M.D.*

I AM grateful for the privilege of serving as your president this *particular* year. This July, we enter a new era in American Medicine. Organized medicine has just finished the last of a long series of hard-fought battles, the first of which took place almost a half-century ago. Our casualties have been many. We have alienated many of our friends, aye, even many of our members. We have spent no small amount of our funds to support this war. It is time we took stock of organized medicine, its purpose, its members, its future.

Organized medicine has not always been ultra-conservative. We have been quick to adopt new techniques and medicines, yet extremely wary of threats to our traditional ways of practice. Our economics are still those of laissezfaire. We have so long argued against socialized medicine that we may have lost sight of the social revolution that has taken place around us.

We have affirmed and reaffirmed that no one is denied medical attention because of poverty, that we serve the poor equally with the rich. Does any physician really believe this to be true? Have enough doctors volunteered to serve our free clinics, to take their turn on our hospital wards? Do we all give generously enough to our local charities? How many would volunteer to give one day a month to man our emergency rooms to care for the indigent? The truth is we are nostalgic. We ignore the fact that medicine has become sophisticated and its costs no longer minimal. Today, our services, even if given free, will not provide cures without the help of expensive drugs and hospital therapy. True, we have encouraged our patients to have insurance coverage. How often have these proved completely inadequate? And what have we proposed to do about it?

Now is the time for the voice of American medicine to be once again a voice of action; time for an end to reaction; time for town and gown, civilian and government physician to join together to try to fulfill the dream of decent medical care available to all. Such a thought is idealistic, but if we fail to take a fix on Arcturus, we may never get off the ground.

As we face the population explosion, man is no longer self-sufficient. Urbanization leaves us no longer isolated communities. Our numbers are already so great that our wastes are choking us, polluting our waters, the very air we breathe. Local control of environmental health is no longer possible. Our vehicles kill more of us than the bullets of our enemies. Not all our poor are unwilling to work. Some have been displaced by automation. Many lack education, or earn less than enough to afford good medical care, adequate housing, education for their children, provision for retirement.

Why, then, do we fight social progress? Elsewhere, physicians lead in social progress. This was once true in these United States. It is time to resume the leadership we abdicated.

Obviously, we cannot agree with all the government give-aways pushed as social progress. Many of these are dangerously socialistic, but not all social reform is socialistic or communistic. If capitalism is to be saved, it must meet the needs of the time, not ignore them. We must take our heads out of the sand.

---

†*Summary of Presidential address, Fayette County Medical Society, March 9, 1966.*

**1966 President, Fayette County Medical Society.*

American medicine *has* reached a high state of advancement. Can private practitioners take all of the credit?

Our present untenable political position discourages membership in our Society of the young men of medicine, those still in training, and of physicians in government and academic medicine. We have not always held this position. Our AMA committees from 1915 to 1920 recommended a system of compulsory federal sickness insurance as the best solution to the problem of adequate distribution of medical care. Many of the features of PL 89-97 resemble these old recommendations.

From 1931 until 1937, we repeatedly rejected Blue Cross. We grudgingly accepted Blue Shield, and later Kerr-Mills to fight less palatable bills. In the struggle against Public Law 89-97, we proposed that sorry thing called Eldercare. These were all defensive battles. Not once in all those years did organized medicine produce anything constructive. We allowed labor and politicians all the initiative.

PL 89-97 provides too much control by the Secretary of HEW. The AMA did not fight to improve this law but insisted it was unnecessary. Our arguments were unconvincing.

Now we have PL 89-97. What are we going to do about it? We heard many cries of non-participation. These were sincere cries of anguish, such as a woman in labor might make with her pains, but as surely as her babe will be born, so surely will physicians participate. What hospital will keep on its staff physicians who fail to certify and recertify patients' need for hospitalization? The required utilization committees are being established. Is this not participation? Who will refuse to bill a patient on the required form so that patient will be reimbursed? How many physicians are pleased to be relieved of medical expenses of their elderly parents? How many, though vocally opposing third-party medicine, will capitulate, and have patients assign their benefits directly to the doctor? Now is the time to put one's money where one's mouth has been. We can be free or we can be bought.

As a matter of fact, one could argue that PL 89-97 is not socialized medicine, but only socialized insurance. Further, the insurance companies are encouraging their eligible customers to take the voluntary physicians' service coverage.

The regional centers for stroke, cancer, and other diseases are another story. Let us analyze this plan carefully, working to keep the good and to change the dangerous portions.

The image of medicine has been tarnished. Although labor and politicians have dimmed our brightness, we are not entirely blameless. If we are to regain the respect of our fellow citizens, let us show by our character, our way of life, our desire to render service that we are worthy of such respect. Let us divest ourselves of opportunistic allies, both the extremists on the right and on the left. We are not the associates of Big Business. Indeed, they abandoned us a long time ago. We are intellectuals with our feet on the ground, not with feet of clay.

Where do we go from here? Our job as organized medicine is to provide the best possible medical care, including preventive care for all, while safeguarding the freedom of our profession, and maintaining its dignity. We must consider whether our mission can be accomplished by our present methods of education, practice, and research. If not, we must seek new ways. We cannot reach Utopia, but we can improve.

We must see that the present emphasis on research in our medical schools is kept vital, without losing sight of the primary purposes of training students and treating patients.

Let us join together in a revitalization of American medicine. Individually, let us become better physicians, setting an example to others in our personal and community lives, placing service ahead of material rewards. As organized medicine, let us strive to make the AMA represent *all* physicians. It is the duty of able physicians to assume leadership in organized medicine at all levels. Physicians in medical schools, in research institutions, and in government must return to join the private practictioners in leadership of the AMA.

We in organized medicine must become a symbol of forward thinking, planning action. Let us abandon our policy of reaction. Only then can the goal of the best possible medical care for all be achieved.

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5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

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Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libida, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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There is a distinct advantage in a small state meeting such as ours over the massive and crowded national conventions that we attend every year. Recognized authorities in their respective specialties will be there to be sure. You have read of them in this and preceding journals. But they will speak before small audiences; one may even ask a question and hear the answer. You may buttonhole the speaker after the session and ask him to elaborate. You may discuss the subject at length with your friends and gather more information perhaps than was garnered from the formal presentation. You will at least learn from your colleague that his problems are the same as yours, or even worse, and that neither has he found a satisfying solution. We are bound to return home wiser, more confident and self assured.

Let us speak first of pleasure, next of learning and last of duty. There are annually new or old questions to which an answer must be found. The K.M.A. cannot function effectively without the help of every member. If you are an officer or trustee you bear a specific responsibility; if you are a delegate the house cannot perform well in your absence; if you are neither you still have a duty as a member to express your opinion before the assembly or in reference committees and to carry a well informed opinion home with you.

Will look for you in Louisville September 20th, 21st and 22nd. Good morning!

SAM A. OVERSTREET, M.D.

We Can Help

OUR daily papers report that crime and juvenile delinquency are on the increase in Kentucky as is true throughout the country. More than 30,000 serious crimes are committed in the state in any year, and a large percentage of these are charged to persons 18 years old or younger. There were more than 4,500 auto thefts, 266,000 burglaries, and 164 murders last year. The public is blamed with apathy and indifference regarding this apalling increase. Whether this charge is justified or not we need to be aroused and alert to apply individual effort, help, professional and financial support to every reasonable means of reducing crime.

It is difficult to understand the motivation in most instances of criminal acts. A young skid row habitue in Chicago willfully murders eight nurses — a month later a student of high military and scholastic record premeditatedly fires upon a great number and kills sixteen on the campus of a leading state university. Juvenile delinquency knows no social nor economic limitations. Neither criminologists, teachers nor social welfare specialists have approached an answer either to the cause

or remedy. In such a dilemma it is sought to promote extensive and nation-wide research upon the problem. The Mayor of Louisville and many other concerned individuals propose that police methods be reviewed and improved because the present crime deterrents seem ineffective.

One thing is certain. The proper training and occupation of youth groups is the first and most effective means toward the prevention of crime. In our cities those neighborhoods with active settlement houses, civic centers, boy's clubs or church sponsored youth activities are able to show an appreciable improvement in the rates of delinquency.

In Louisville recently, Mr. Wilson Wyatt took the initiative in calling together a group of representative citizens to activate a local committee to support and extend the work of the National Council on Crime and Delinquency. This is a nonprofit organization, active since 1907, seeking to help, control and treat crime and persons with criminal intent. It proposes to carry out research, set standards and encourage wider interest and help among citizens. This council has conducted some important studies of Kentucky's correctional systems and been helpful in suggesting some much needed reforms. It is a participating agency with the Community Chest of Louisville and Jefferson County. Dues and contributions are tax deductible. The Ford Foundation has given $1,250,000 to make a start in expanding its nation-wide citizens action program to combat crime.

Physicians are never unresponsive to civic concerns. They are supposed to be always among the leaders in social, moral and educational endeavors. They have a special and dual responsibility in this crusade against crime because they, perhaps more than any other professional group, have an opportunity to influence the social and moral development of youth.

A recent issue of the *Medical Tribune* carried a page discussion by physicians on our responsibility in the control of juvenile delinquency. Ben Sheppard, M.D., a pediatrician in Coral Gables, Florida, serves also as a judge of the Juvenile Court in Miami. He believes many danger signals are purely physical—hearing difficulties, poor reading ability, short attention span, complaints from the schoolroom, inability to concentrate on any one thing very long. Such clues should command the physician's attention and prompt him to advise the parents of helpful guidance and preventive measures. He regrets that obvious mental and emotional problems in children are for the most part ignored by medical men unless help is specifically requested by the parents—and parents too seldom ask for the physician's advice when it is obviously needed.

Ruth E. Church, M.D., Medical Director of the Waukesha County, Wisconsin, Health Department, urges that the physician, if too busy or uninformed himself for adequate counseling of children and parents, take care to refer them to appropriately trained physicians or welfare agencies where proper guidance and help can be obtained. We have a civic responsibility to report to the proper agencies acts of delinquency, venereal disease, unauthorized use of drugs or behavior suggestive of moral defectiveness or mental illness. The child as well as the parent should be given opportunity to present his problems and should be given every confidence that we are anxious to help him find a satisfactory solution.

W. Alan Hume, M.D., has a helpful suggestion—responsibility begins at home. Let us first see that training at home is adequate. Neither the psychiatrist, the church, the school nor the court can assume responsibility that properly rests with the parents.

Physicians are regarded as influential leaders in any community. We can well exert a stronger effort than we have in the prevention of delinquency and crime. Our voice should be heard more often before high school and college groups, before church and civic gatherings, on radio or television, whenever invited to participate. Consultation in our offices could well be more painstaking and definitive; membership in and financial contributions to organizations directing their attention to the study and prevention of crime are a part of every progressive citizen's responsibility. Let us be careful to lead and to help in every community-wide endeavor toward this end.

SAM A. OVERSTREET, M.D.

ORGANIZATION SECTION

Dr. Walter Judd Keynote Speaker At '66 President's Luncheon

Medicine's place in the future and the influence it should exert will be explored by one of the country's outstanding speakers — Walter H. Judd, M.D., Washington, D.C.—at the 1966 KMA President's Luncheon in the Flag Room of the Kentucky Hotel, Wednesday, September 21.



Doctor Judd

In order to accommodate the large crowd expected to attend this year's luncheon because of the unusually high calibre of the speaker, the luncheon will be held in the Flag Room of the Kentucky Hotel instead of in the Terrace Room as originally planned.

Everett H. Baker, M.D., KMA president, who announced the change, said he was particularly grateful to the Woman's Auxiliary for graciously relinquishing the Flag Room for the Association's use.

Since demand for the tickets to the President's Luncheon is expected to be great, you are urged to get your tickets early. They may be purchased at the same time you register for the Annual Meeting.

A noted spokesman for Medicine, Doctor Judd's topic will be "Can the Best be Better?". He has appeared on many radio and tv programs and is in demand as a speaker to groups throughout the nation. Doctor Judd served 20 years in the U.S. Congress, lived in China 10 years as a medical missionary, and will be remembered by many for his keynote address at the Republican National Convention in 1960.

Another feature of the luncheon will be presentation of the three top KMA awards

Color TV Clinics, Top Speakers Highlight Annual Meeting

"Color television clinics, nationally known guest speakers, high calibre specialty group sessions, scientific and technical exhibits, an outstanding President's Luncheon speaker, plus the fellowship of U of L reunions and the annual golf tournament should combine to make this year's KMA Annual Meeting a "must" for all Kentucky physicians," according to Everett H. Baker, M.D., Louisville, KMA president.

"We feel that this year's program is unusually excellent," Doctor Baker said,"and we hope that members will avail themselves of this opportunity for postgraduate education and reunion with old friends."

Five Color TV Sessions

The general sessions of the meeting at the Convention Center from September 20-22 will be highlighted by five closed circuit color tv clinics originating at the U of L Medical Center through the auspices of Smith Kline & French Laboratories. Sixteen guest speakers will be featured at the meeting.

Seventeen scientific and 75 technical exhibits are planned to offer physicians a chance to keep abreast of the latest developments in medicine and allied fields.

Special "hospitality" tours of the U of L Medical School will be a new addition to the traditional medical school alumni reunions held in conjunction with the Annual Meeting.

The Annual KMA golf tournament will be held at the Louisville Country Club on September 19.

AMPAC, KEMPAC Speakers Slated For Annual Seminar Oct. 19

George J. Lawrence, Jr., M.D., Flushing, N.Y., representing the American Medical Political Action Committee (AMPAC) will share the podium with Kentucky Educational Medical Political Action Committee (KEMPAC) speakers, Senators Paul J. Fannin (R. — Ariz.) and Daniel K. Inouye (D.—Hawaii) at the fourth annual seminar, Monday evening, September 19, at the Kentucky Hotel.



Doctor Lawrence

Doctor Lawrence, past secretary - treasurer of AMPAC and a member of its Board of Directors, is president of the Queens County Medical Society, chairman and counselor of the First District Branch, New York State Medical Society, and is diplomate of the American Board of Obstetrics and Gynecology, F.A.C.O.G., F.A.C.S.

"Future Legislative National Programs Relating to Medicine" is the theme of this year's seminar. A reception in the Flag Room at 6 p.m. will precede a dinner at 7 p.m., according to Richard F. Great-

house, M.D., Louisville, secretary of the KEMPAC Board of Directors, The seminar will follow the dinner.

A native of Ashland, Ky., Senator Fannin was elected to the U.S. Senate in 1964 and is a member of the Senate Interior and Insular Affairs Committee and the Senate Labor and Public Welfare Committee. A 1930 graduate of Stanford University, he is a former governor of Arizona. Senator Fannin was a member of the President's Civil Defense Advisory Council in 1963-4.

Senator Inouye was elected to the Senate in 1962, after serving two terms as Hawaii's first representative. Chairman of the speakers bureau of the Democratic Senatorial Campaign Committee, he is on the Armed Services and the Public Works Committees. Senator Inouye lost his right arm in battle while serving in Italy and France during World War II.

State Board of Health Elects Dr. Baughman, Dr. Archer

At the last meeting held by the State Board of Health in August, B. B. Baughman, M.D., Frankfort, was elected chairman of the Board. George P. Archer, M.D., Prestonsburg, is the new vice-chairman.

In other business, the Board renewed the appointment of Russell E. Teague, M.D., Frankfort, as Health Commissioner for the next four years.

Doctor Baughman succeeds O. Leon Higdon, M.D., Paducah, as chairman of the Board. Doctor Baughman is past chairman of the Kentucky Medical Association Board of Trustees and Doctor Archer is past president of KMA.

This was the first meeting for Gabe A. Payne, Jr., M.D., Hopkinsville, who was appointed to take Doctor Higdon's place when the former's term expired. Doctor Payne is currently a member of the KMA Board of Trustees.

Dial 584-2201, Message Center For Emergency Call Service

During the KMA Annual Meeting, September 20-22, your telephone number will be **584-2201 Code 502,** the number of the message center located in the entrance lobby of the Center and in the Scientific Assembly Hall.

Please leave this number at your home, office or hospital if you wish to be contacted while attending the meeting. All messages will be on file and may be picked up at the message center. You are asked to check there frequently for your calls. *Only* emergency calls will be posted on the blackboards in the entrance lobby and the Scientific Assembly Hall.

For your convenience you may leave a message to be delivered to friends or fellow physicians who are also attending the meeting. In order to receive calls and messages quickly you are urged to make full use of the message booth.

If you wish to be reached Monday, September 19 (beginning at 9 a.m.) while attending the meetings of the House of Delegates, or Wednesday evening, September 21 (starting at 6:30) your calls should be directed to the Terrace Room. The phone number at the Kentucky Hotel is **587-1181.**

Board Elects Journal Editors; Creates Position of Asst. Ed.

Walter S. Coe, M.D., Louisville, was elected Editor of the *Journal of the Kentucky Medical Association* by the Board of Trustees at its August 3 meeting. Doctor Coe succeeds Sam A. Overstreet, M.D., Louisville, whose resignation was accepted by the Board after having completed four consecutive terms as Editor of the *Journal.*



Recommendations provided that an addition to the *Journal* staff be made by creating an office of assistant editor. Elected for this position was Walter I. Hume, Jr., M. D., Louisville, a 1949 graduate of the Harvard Medical School. Doctor Hume, is certified by the American Board of Surgery, and is a member of the American College of Surgeons. He will meet with the regular editors at the Monday Editors' Meetings.

Further recommendations had been made that Doctor Overstreet continue to serve on the *Journal* staff as associate editor, because of his interest and broad knowledge of the physicians over the state. Doctor Overstreet was medical editorial editor for several years before being elected as editor.

A graduate of the University of Louisville School of Medicine in 1943, Doctor Coe served for several years as Book Review Editor of the *Journal,* before serving four years as associate editor. Doctor Coe, an internist, is serving his second term as President of the Louisville Heart Association. He is an associate professor of medicine at the University of Louisville School of medicine.

District V Ob-Gyn Conference Scheduled for October 13-15

A conference on Obstetric, Gynecologic and Neonatal Nursing will be held by the District V Fellows October 13-15 at the Stouffer Inn, Louisville. The District's Junior Fellows will hold a one-day meeting on October 12, during which they will spend the morning at the Louisville General Hospital, and the afternoon session at Stouffer Inn.

According to John D. Gordinier, M.D., Louisville, the forthcoming program will contain carefully selected subjects, and all Fellows and Junior Fellows are urged to attend.

The District V Conference on Nursing, held at the Brown Hotel, will present a number of scientific papers at seminars, divided according to obstetric, gynecologic, and neonatal nursing subjects.

Dr. Scott, 1939 KMA President Passed Away, July 22

John W. Scott, M.D., Lexington, past president of the Kentucky Medical Association in 1939, and recipient of its Distinguished Service Award, passed away July 22, 1966. Shortly before his death, he fractured a hip in a fall. He remained active, alert and in good spirits to the day of his passing.



Doctor Scott

Doctor Scott is well remembered by Kentucky physicians for his many years of active and most effective service in the KMA House of Delegates. He was a man of strong convictions, articulate, and ready at all times to support any position he had taken. Yet, he was known and respected throughout the Association for being fair-minded and always having the best interest of his profession and the people it served at heart.

He began his practice of medicine in 1896, and it was not until 1960 that he retired. Nevertheless, he maintained his association with the staff at both Good Samaritan and St. Joseph Hospitals, which he served during his practice.

He was a past president and dominant figure for many years in Fayette County Medicine, held the title of Clinical Professor of Medicine at the University of Kentucky College of Medicine, was a leader in public health activity and active in community affairs.

"Friday Nighter's Cup" Awarded To Doctor Pennington

Robert E. Pennington, M.D., London, was the recipient of the Friday Nighter's Cup presented at the 32nd Annual Laurel County Homecoming, August 26. The award is given for outstanding service to the community.



Doctor Pennington

The Homecoming is held traditionally on the weekend of the full moon in August. At each of the evening programs, the Homecoming, oldest countryside event of its kind in Kentucky, honors a native of the County who has made significant contributions in his chosen field.

A graduate of the University of Pennsylvania in 1936, Doctor Pennington completed his training in surgery in 1941 and has practiced in London since. He served in the China Theatre during World War II and was discharged by the U.S. Army in 1946 as a lieutenant colonel, after having won the Bronze Star Medal.

He is a member of the Health Advisory Council to the Appalachian Regional Commission, the Kentucky Health Facilities Advisory Council, the Board of Trustees of Sue Bennett College in London, the Laurel County Development Association, Kentucky Chamber of Commerce and the Methodist Church.

Dr. Stovall, KMA Past-President Dies Suddenly at His Home

J. Watts Stovall, M.D., 84, former president of the Kentucky Medical Association, died in July at his home in Grayson. Doctor Stovall was a former member of the Carter County Board of Education and was a member of the State Board of Health for 36 years.



Doctor Stovall

Before he entered Kentucky University Medical Department, Louisville, at age 19, Doctor Stovall had served in the Spanish-American War, and the Philippines campaign under General Douglas MacArthur. He received his M.D. degree in 1905 and returned to Grayson to share a practice with his father.

Later he took postgraduate courses in Chicago, and at Tulane University, New Orleans. In 1927 Doctor Stovall organized the Stovall Hospital in Grayson, where he was Chief Surgeon and Superintendent.

Doctor Stovall served on the KMA's first grievance committee, and he remained active in the KMA for many years. His devotion and participation in the medical profession and civic affairs will long be remembered.

Louisvillian to Head AAGP

Immediate past president of the Kentucky Chapter of the American Academy of General Practice, Carroll L. Witten, M.D., Louisville will be inaugurated Wednesday evening, October 12, as AAGP president at the Sheraton Hotel in Boston.

The October 10-13 AAGP meeting marks the first time this meeting has been held in New England and in the Fall. Some 3,000 physicians are expected to hear presentations by 31 medical authorities.

Archer Park, a carefully specialized playground facility, occupying 22 acres in Prestonsburg was recently dedicated. The park was named for Mayor **George P. Archer, M.D.,** past president of KMA.

Kentucky Supplies 38 Physicians For Duty in Armed Forces

Thirty-eight Kentucky physicians have either been inducted into the armed forces in recent months or have accepted commissions and are subject to call, according to best available information, J. Duffy Hancock, M.D., Louisville, chairman of the Kentucky Advisory Committee to Selective Service, reported.

Becouse of the difficulty in following developments, despite the cooperation of the State Selective Service system, it is impossible to get absolutely accurate information, Doctor Hancock said. He urged that the KMA Headquarters Office be advised immediately if there are errors in the following list of names subject to call.

Physicians in Military Service

Douglas R. Alvey, M.D.. Franklin
Gerald Berman, M.D., Louisville
James S. Brashear, M.D., Central City
Irvin E. Bronner, M.D., Louisville
William K. Burkhart, M.D., Lexington
Forrest Wayne Calico, M.D., Lexington
Ray Cave, M.D., Leitchfield
Ronald G. Chism, M.D., Louisville
Fulton Greer, M.D., Mayfield
Gordon L. Gutmann, M.D., Louisville
Thomas W. Hagan, M.D., Louisville
James Hamilton, M.D., Eddyville
Charles D. Howard, M.D., Springfield
Elton R. House, M.D., Henderson
Chris S. Jackson, M.D., Danville
B. J. Kidd, M.D., Louisville
Jerry W. Martin, M.D., Bowling Green
William L. Miller, M.D., Louisville
Alvin D. Poweleit, M.D., Erlanger
Carl B. Rankin, M.D., Louisville
Samuel H. Reid, M.D., Danville
Bernard F. Sams, M.D., Louisville
Ted Joe Sanders, M.D., Flatwoods
Robert P. Schiavone, M.D., Louisville
Charles B. Severs, M.D., Valley Station
W. L. Thompson, M.D., Louisville
Lewis Eugene Wash, M.D., Lawrenceburg
Thomas R. Watson, M.D., Louisville
Chalmer S. Wheeler, M.D., Louisville
Ardy C. Wright, M.D., Hazard

Physicians Who Have Accepted Commissions

Clegg Farmer Austin, M.D., Murray
Donald Clyde Barton, M.D., Corbin
Wallace Earl Combs, M.D., Nicholasville
Wendell Elwood Gordon, M.D., Benton
Vernon Franklin Hart, M.D., Lexington
Bradford E. Mutchler, M.D , Paducah
James Wayne Roney, M.D., Lebanon Junction
Curtis Lee Songster, M.D., Vine Grove
James J. Williamson, M.D., Ashland

Ky. Pharmacy Group Elects Weisert As President

The 89th Convention of the Kentucky Pharmaceutical Association was held July 25-27 at the Lamplighter Motel in Covington. Newly elected 1966-67 president is Thomas L. Weisert, R. Ph., Louisville, who succeeds John H. Oehlschlaeger, Jr., Paducah.



A graduate of the University of Kentucky College of Pharmacy and a member of Kappa Psi Pharmaceutical Fraternity, Mr. Weisert was registered in 1954 and began work for his father at Weisert's Pharmacy in Louisville. He has been employed by the Taylor Drug Stores, Louisville, since 1956, after two years with the Army Medical Service Corps.

During the September 22 meeting of the KPA Board of Directors, which will be held at Kentucky Lake, plans will be made for the 1967 KPA annual convention, according to President Weisert.

1966 Diabetes Detection Drive Set for Week of Nov. 13-19

The week of November 13-19 has been set aside for the Diabetes Detection and Education Drive this year, according to Irving F. Kanner, M.D., Lexington, chairman of the Kentucky Medical Association's Diabetes Committee. The goal of the annual drive is to find unknown diabetics and help them to live longer and more useful lives.

Kentucky was the first state to initiate an annual Diabetes Detection and Education Week and this year marks the 16th annual drive in Kentucky. In the previous 15 years, approximately 2,500 cases of diabetes have been found during the week set aside for this public service program.

Doctor Kanner urges all Kentucky physicians to take part in this program, to order their supply of free Clinistix from their county chairman, and to check urine samples free during the week of the drive. Doctor Kanner stated that, "We will have a most successful drive if each doctor of medicine gives his full cooperation", and added that, "The annual Diabetes Detection and Education Drive can certainly help simplify the problems of control of the disease."

ACS to Meet Oct. 10-14

The 52nd annual Clinical Congress of the American College of Surgeons will be held in San Francisco, Oct. 10-14, marking the largest meeting of surgeons in the world. More than 12,000 Fellows will have an opportunity to attend the five-day program, featuring reports, postgraduate courses, panel discussions, films, and telecasts, which will cover every phase of surgery.



D. Lane Tynes, executive officer of Blue Cross-Blue Shield in Kentucky, hands the keys to the new Blue Cross-Blue Shield Mobile Information Center to Michael Chandler, manager of the traveling office. The purpose of the project is to bring information about health care protections to smaller communities throughout Kentucky. The unit will also be used at fairs and at other gatherings.

Eleven U of L Class Reunions Planned During Meeting

Leslie Shively, Director of Alumni Relations, University of Louisville, has announced the names of the chairmen for class reunions for the University of Louisville School of Medicine that will be held this year in connection with the KMA Annual Meeting.

This year plans have been made to hold eleven class reunions. The oldest would be those who were graduated in 1911. The 1916 group will have their 50th anniversary. The 1921, their 45th and so on.

Special tours of the medical school and medical center area have been arranged for the reunion classes. The alumni are urged to meet at 4:00 p.m. Tuesday, September 20, in Rankin Ampitheatre from which point the tours will begin. Following the tours Kentucky ham and beaten biscuits will be featured at a social hour according to the alumni office. All classes are planning reunion dinners on the 20th.

Classes and chairmen are as follows:

1911 Oscar O. Miller, M.D., Louisville
1916 Handled by Alumni Office
1921 E. R. Gernert, M.D., Louisville
1926 K. Armand Fischer, M.D., Louisville
1931 William K. Keller, M.D., Louisville
1936 George F. McAuliffe, M.D., Louisville
1941 Frederick Ehrman, M.D., Louisville
1946 Alan Willner, M.D., Clarksville, Ind.
1951 Lyle Havens, M.D., Jeffersonville, Ind.
1956 David C. Shipp, M.D., Louisville
1961 Jay Koby, M.D., Louisville

Ky. Pharmacist New Pres-Elect of National Group

George W. Grider, a Danville pharmacist who serves as curator of the McDowell House and Apothecary Shop, was recently chosen president-elect of the American Pharmaceutical Association. He will be installed as APhA president at the National Convention in April, 1967 and will serve for one year.

A 1940 graduate of the Louisville College of Pharmacy, Mr. Grider was appointed to a five-year term on the Kentucky Board of Pharmacy in 1955 and then reappointed to an unprecedented additional term. He was chairman of a special committee for restoration of the McDowell Apothecary Shop. Under his direction this committee raised $40,000 and completed the restoration in 1959.

President-elect Grider has served his local state and national associations in various capacities. He was elected president of the American Institute of the History of Pharmacy in 1964.

Dr. Denham Attends SREB Workshop

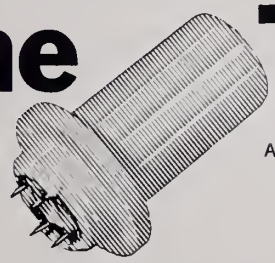
Mitchell B. Denham, M.D., Maysville, was one of eight Kentucky Legislators chosen by Governor Edward T. Breathitt to attend the annual conference of the Southern Regional Education Board at Asheville, N.C., July 27-30. Doctor Denham, representative from District 70 (Bracken and Mason Counties), is speaker-pro-tem of the House and is serving in various capacities on 11 committees of the House. In addition to his legislative activities, he is a KMA trustee from the Ninth District.

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Fifty Groups Plan Meetings In Conjunction with KMA Session

Since you may be involved in one or more of the 46 related and miscellaneous meetings held in conjunction with the 1966 KMA Annual Meeting September 20-22, you may want to carefully check the following list which gives date, hour and location of each session.

Arrangements for these meetings, in the great majority of cases, were made by or with assistance of the KMA staff. The list includes all known meetings that have been set up by press time.

Sunday, September 18

12:30 p.m. KMA Board of Trustees Luncheon Meeting, Parlor A, Kentucky Hotel
5:00 p.m. Social Hour, U. of K. Medical School, Parlors B and C, Kentucky Hotel
6:30 p.m. Board of Directors, Blue Shield, Dinner, Ship Room, Kentucky Hotel

Monday, September 19

8:00 a.m. Awards Committee Breakfast, Room 201, Kentucky Hotel
8:30 a.m. Orientation Program, New KMA Members, Mirror Room, Kentucky Hotel
9:00 a.m. KMA House of Delegates Meeting, Terrace Room, Kentucky Hotel
9:00 a.m. Kentucky Diabetes Association Meeting, Ship Room, Kentucky Hotel
10:00 a.m. Tee-Off Time, KMGA Golf Tournament, Louisville Country Club, Tee-Off Deadline 2:00 p.m.
12:30 p.m. Reference Committee Chairmen, Luncheon, Room 317, Kentucky Hotel
2:00 p.m. Seven Reference Committee Meetings, Parlors A, B, C and D. Rooms 203, 204 and 205, Kentucky Hotel
6:00 p.m. KEMPAC Reception, Banquet and Seminar, Flag Room, Kentucky Hotel

Tuesday, September 20

7:30 a.m. Panel on "Modern Concepts in Pathogenesis, Prevention and Treatment of Erythroblastosis Fetalis", Breakfast, Room 201, Kentucky Hotel
12:00 noon KMA Maternal Mortality Study Committee, Luncheon Meeting, Room 204, Kentucky Hotel
12:00 noon Executive Committee, Kentucky Obstetrical and Gynecological Association, Room 203
3:00 p.m. Kentucky Plastic Surgeons Meeting, Parlor C, Kentucky Hotel
5:30 p.m. Kentucky Chapter, American College of Chest Physicians, Social Hour and Dinner, Ship Room, Kentucky Hotel
6:00 p.m. Kentucky Flying Physicians, Reorganizational Meeting, Room 317, Kentucky Hotel
6:30 p.m. Kentucky Chapter, American Academy of Pediatrics, Social Hour and Dinner, Ballroom A, Stouffer's Inn
6:30 p.m. Kentucky Orthopaedic Society, Social Hour and Dinner, Pendennis Club
6:30 p.m. Kentucky Urological Association, Social Hour and Dinner, Plantation Room, Sheraton Hotel

Wednesday, September 21

7:00 a.m. Committee on Medicine and Religion, Breakfast, Parlor A, Kentucky Hotel
7:30 a.m. KEMPAC Board of Directors, Breakfast, Parlor B, Kentucky Hotel
7:30 a.m. Panel on "Management of Infections", Breakfast, Room 201, Kentucky Hotel
7:30 a.m. Trustees of KAGP Group Life Insurance Plan, Breakfast Meeting, Room 205, Kentucky Hotel.
9:00 a.m. State Board of Health Meeting, Room 317, Kentucky Hotel
11:50 a.m. President's Luncheon, Flag Room, Kentucky Hotel
5:00 p.m. Board of Trustees Meeting, Parlor B, Kentucky Hotel
6:00 p.m. Board of Trustees Dinner, Parlor A, Kentucky Hotel
6:00 p.m. House of Delegates Subscription Dinner, Terrace Room, Kentucky Hotel
6:30 p.m. Kentucky EEN&T Society, Dinner, Holiday Inn, N. E.
7:00 p.m. House of Delegates Meeting, Terrace Room, Kentucky Hotel

Thursday, September 22

7:00 a.m. MEA Liaison Committee Breakfast, Room 203, Kentucky Hotel
7:30 a.m. Panel on "Drugs, Their Actions and Reactions", Breakfast, Room 202, Kentucky Hotel
7:30 a.m. Kentucky Society for the Prevention of Blindness, Breakfast, Parlor B, Kentucky Hotel
8:15 a.m. KMA Cancer Coordinating Committee Breakfast Meeting with Cancer Clinic directors, Parlor C, Kentucky Hotel.
12:00 noon KMA Board of Trustees Luncheon, Parlor A, Kentucky Hotel
12:00 noon Kentucky Dermatological Society, Luncheon, Parlor C, Kentucky Hotel
12:30 p.m. Kentucky EEN&T Society, President's Luncheon, Ship Room, Kentucky Hotel
12:30 p.m. Kentucky Chapter, American College of Surgeons, Luncheon, Room 317, Kentucky Hotel
2:00 p.m. County School Health Chairmen, Meeting, Room 208, Convention Center
5:00 p.m. Kentucky Society of Anesthesiologists, Social Hour. Parlor B, Kentucky Hotel
6:00 p.m. Kentucky Chapter, American College of Radiology, Social Hour and Dinner, Sheraton Hotel

Congress on Medical Quackery in Chicago, Oct. 7-8

"Quackery: 1966" is the theme of the Third National Congress on Medical Quackery at the Pick-Congress Hotel in Chicago on October 7-8.

Aimed at calling attention to the perils of present-day fads and fallacies in the health field, the Congress is sponsored jointly by the AMA and the National Health Council. Joint announcement of the Congress was made by F.J.L. Blasingame, M.D., AMA executive vice-president, and Peter G. Meek, executive director of the National Health Council.

Two previous National Congresses on Medical Quackery, in 1961 and 1963, were attended by more than 600 persons representing the fields of education government, and professional and voluntary organizations. J. Campbell Cantrill, M.D., chairman of the KMA Council on Legislative Activities, and Gilbert A. Armstrong, of the KMA staff, will attend the

(Continued on Page 794)

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Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
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Geigy

(Continued from Page 792)
Congress. For additional information contact: John G. Thomsen, M.D., chairman, AMA Committee on Quackery, 535 N. Dearborn, Chicago, 60610.

Medical Progress Demonstrated By Scientific Exhibits

Sixteen scientific exhibits, featuring the most recent developments in medical research and techniques, will be presented this year at the KMA Annual Meeting, according to Benjamin B. Jackson, M.D., chairman of the Committee on Scientific Exhibits.

Located in the Convention Center between the Technical Exhibit Hall and the Scientific Assembly Hall, the exhibits are conveniently arranged for easy access.

The exhibitor with the outstanding scientific exhibit at the meeting will be presented with a plaque by KMA and in addition will receive a check in the amount of $200 and a certificate from Mead Johnson Laboratories as winner of the Aesculapius Award. Each exhibitor will also receive a certificate from KMA.

A list of exhibitors follows:

Pathophysiology and Therapy of Hemorrhagic Shock
Lewis C. Mills, M.D.
Hahnemann Medical College and Hospital

Study of a Prison Population: Testing Ground for New Drugs
Harry Brick, M.D.
W. H. Doub, Jr.
W. C. Perdue, M.S.
Virginia State Penitentiary

Renal Homotransplantation in Man
D. M. Hume, M.D.
H. M. Kauffman, M.D.
R. J Cleveland, M.D.
Medical College of Virginia

The Surgical Treatment of Post-Surgical Dumping and Diarrhea
George B. Sanders, M.D.

Surgical Treatment of Baldness
James W. Burks, M.D.
John M. Yarborough, Jr., M.D.
Tulane University

Thrombectomy for Acute Iliofemoral Venous Thrombosis
Giles Stephens, M.D.
St. Joseph Infirmary, Louisville

Plannet Parenthood
Louisville Planned Parent-Hood Clinic, Inc.
Ronald L. Levine, M.D., Medical Director

Surgical Treatment of Involuntary Movement Disorders
B. O. Rand, M.D.
Horace Norrell, M.D.
Lexington Veterans Administration Hospital

Evaluation of Analgesics and a New Episiotomy Procedure in Relief of Post-Partum Pain and Trauma
J. Morton Schneider, M.D.
Ralph C. Benson, M.D.
Raphael B. Durfee, M.D.

Progress in Surgery for Cancer of the Head and Neck
Fitzhugh Mullins, M.D.
Condict Moore, M.D.

Cardiac Arrest and Resuscitation
George F. Brockman, M.D.
Robert E. Robbins, M.D.

Depletion of Storage Iron in the Female
Wilk O. West, M.D.
Lexington Clinic

Possible Consequences from Irresponsible Use of Ionizing Radiation
Kentucky State Department of Health
Radiological Health Program

Vascular Changes in Arthritis of the Hand
T. R. Marshall, M.D.

Multi-Phasic Health Screening
Malcolm L. Barnes, M.D.

Early Therapy in the Treatment of Bacterial Infections
Malcolm L. Barnes, M.D.

Glaucoma Screening Plans Set

Tentative plans for glaucoma screening during the KMA Annual Meeting have been made as a cooperative effort of the Kentucky EEN&T Society and the Kentucky Society for the Prevention of Blindness.

The glaucoma screening project will be set up in the Louisville Convention Center and will be available to all KMA members attending the Annual Session if current plans materialize.

Diabetes Assn. Meeting Sept. 19

The Fifth Annual Scientific Meeting of the Kentucky Diabetes Association will be held September 19 at the Kentucky Hotel, Louisville, preceding the KMA Annual Meeting. The program will consist of four guest speakers and a question and answer panel on Diabetic Complications, the topic of the meeting, according to President William W. Winternitz, M.D., Lexington. All physicians are invited to attend.

Index Shows Drug Prices Down

The Pharmaceutical Manufacturers Association disclosed at press time that the government's wholesale Price Index for ethical drug preparations dropped .3 percent in June to a new record low of 93.8. In other words, prescription ingredients sold by manufacturers for $10 in January, 1961, when the index was begun, were available in June, 1966, for only $9.38. The data was compiled by the Bureau of Labor Statistics of the U.S. Labor Department.

New
low-cost tetracycline/antifungal therapy

for broad-spectrum activity
plus specific antifungal prophylaxis
at significant patient savings

Whenever tetracycline is indicated in these candidates for Candida:

1. diabetic patients



2. nonpregnant women with a history of recent or recurrent monilial vaginitis



3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule *q.i.d.* Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals. *Supply:* Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

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Syracuse, New York

Tetrex-F®

Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.

Tetrex-F is priced lower
than most
tetracycline-antifungal products.

Summary of KMA Board of Trustees Meeting August 3 and 4

The fifth meeting of the Board was held in four sessions beginning early Wednesday afternoon and ending late Thursday.

The Legal Counsel reported that to date he had been unable to find a liability policy covering association officers in carrying out their duties.

The resignation of Sam A. Overstreet, M.D., Louisville, who had served as editor of *The Journal* for eight years was accepted with deep appreciation and his associate, Walter S. Coe, M.D., Louisville, was elected for a two-year term. At Doctor Coe's suggestion, the Board elected Doctor Overstreet as associate editor for a two-year term and created the new post of assistant editor and elected Walter I. Hume, Jr., M.D., Louisville, to fill that post.

The Morehead matter was reviewed and resolutions presented by the Fayette County Medical Society in the area of direct billing and third party connections were carefully considered and recommended to the House of Delegates.

The revising of the fee schedule for the ODMC contract, which had not been changed for six years, was discussed. It was indicated that the renewal date of July 1 had been changed to December 1 and the Executive Committee was authorized to give active consideration to this problem.

The Board expressed its appreciation to the Kentucky Surgical Society for a $1,000 contribution to the McDowell House and picked Ken-Bar Inn, adjacent to and just west of Kentucky Lake State Park for the site of the 1967 Interim Meeting and fixed the date as April 19 and 20.

The Board heard a report of a special joint meeting between the executive Committee and the physician members of the Board of Health, which had been held in executive session. The Executive Committee, as a result of this meeting, had recommended that the Board give consideration to carrying out a study which would provide information on fees that would enable the medical care division of the State Department of Health to predict costs in the implementation of Title XIX. The Board referred the matter back to the Executive Committee and asked it to explore the possibility of such a survey in depth.

Approximately two of the four sessions held during this two-day meeting were devoted to hearing reports of councils and standing committees as provided for in the Bylaws. Since action on each council and committee report will be printed at the conclusion of all of these reports which are considered by the House of Delegates, they will not be reported here.

In considering separate recommendations to the Board from committees and councils, the Board approved the request of the School Health Committee for the use of a room in the Convention Center during the Annual Meeting. A recommendation from the Public Health Committee that KMA encourage county medical societies to participate in the introduction of VD instructions in the schools in the counties, and the request that information on laws relating to infectious diseases be included in KMA Orientation programs was approved.

From the KMA Blood Banks Committee came a recommendation to the Board asking for KMA support of a bill in Congress, S1353, concerning blood banks and anti-trust laws and the approval of a statement relating to payment of money indemnities under health insurance contracts.

A recommendation from the KMA Diabetes Committee concerning the use of blood sugar testing kits to be prepared by the State Department of Health and used by the county medical society diabetes chairmen was disapproved. Reasons given included that this would involve extra expense for the already tight budget of the State Department of Health and that present procedures using Ames products were satisfactory.

The dates of September 7 and 8 were set for the next meeting of the Executive Committee, which would among other things, make nominations for personnel of committees and councils for the coming year.

The Board then set its own schedule for meetings to be held during the Annual Session on September 18, 21, and 22.

Las Vegas is Site of November AMA Clinical Convention

The 20th Clinical Convention of the American Medical Association is scheduled for November 27-30 in Las Vegas, Nevada, according to an announcement from Charles L. Hudson, M.D., AMA president.

Scientific sessions on 18 major topics, three postgraduate courses, breakfast roundtable conferences, closed circuit television and medical motion picture programs, and a variety of scientific exhibits will be included in the four-day program.

All scientific meetings and scientific and industrial exhibits will be in the newly expanded Las Vegas Convention Center. The AMA House of Delegates will meet in the Dunes Hotel and Caesar's Palace.

AHA Award of Honor Presented

The American Hospital Association has presented its first Award of Honor at the first session of the AHA House of Delegates during the 68th. Annual Meeting of the AHA, held in Chicago, August 29-September 1. Senator Lister Hill (D. Ala.) was named recipient of the Award, in recognition of his outstanding contributions to the hospital field and health of the nation.

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

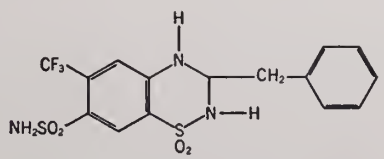
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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to reduce excess fluid
or high blood pressure

Dr. Pellegrino to Leave UK For Position in N.Y.

Edmund D. Pellegrino, M.D., chairman of the University of Kentucky Department of Medicine since its establishment, will become medical center director at a new campus of the State University of New York, Stony Brook, Long Island, on September 15.

Doctor Pellegrino will also be professor and chairman of the Department of Medicine there. A graduate of the New York University College of Medicine, Doctor Pellegrino had been a faculty member there for six years before he came to UK in 1959. He came to Kentucky a year before the UK College of Medicine admitted its first students.

In announcing Doctor Pellegrino's resignation, the executive vice president of UK said, "It is with great regret that we see this outstanding medical educator leave the University, where his services as teacher, administrator and research scientifist have been of major importance".

Grants Made to UK Med. School

The University of Kentucky Research Foundation, Lexington, was awarded $113,916 in federal grants in July. The grants, allocated by the Public Health Service and the National Cancer Institute, will be used for research and clinical training in cancer.

The purpose of the program will be to train students, interns, and local and state practitioners in the use of modern cancer techniques, according to Larry Hinderberger, research administrator at the Medical Center. All of the grants are for continuing programs, but funds are granted for only one year at a time.

Ky. M.D. Honored by the AMA

O. B. Murphy, M.D., Lexington, has been designated as the official American Medical Association representative to the Tenth Congress International Society of Orthopedic Surgery and Traumatology. According to F. J. L. Blasingame, M.D., executive vice-president of AMA, Doctor Murphy was scheduled to attend the conference held in Paris, France, September 4-9.

9 Louisville M.D.'s Join KMA

New KMA members reported by the membership office have totaled nine for the month of August. All of the following doctors are located in Louisville: Fielding W. Daniel, M.D.; William C. Edwards, M.D.; Dean Fitzgerald, M.D.; Gary Hogge, M.D.; Thomas Hutsell, M.D.; Ronald Kaplan, M.D.; Louis Nagel, M.D.; G. Dudley Nelson, M.D.; Robert G. Spurling, M.D.

5 Research Grants Awarded UK

Five research grants totaling $317,439, were awarded to the University of Kentucky's Research Foundation in June by the U.S. Agricultural Research Service. The grants, divided into five projects, will be applied to the following departments: Department of Pathology, directed by Irene Roeckel, Dr. M.Sc., $44,367; Department of Pharmacology, directed by J. W. Flesher, Ph.D., $64,166; Department of Medicine, directed by P. Mandlestam, M.D., Ph.D., and E. D. Rees, M.D., $56,500; Department of Chemistry, directed by E. V. Brown, Ph.D., $86,323; and the College of Dentistry, directed by P. R. Courant, D.M.D., $66,083.

Med. Scholarships Set by UK

The University of Kentucky College of Medicine announced in June, a new scholarship program established and financed by the New York Life Insurance Company. The program, to begin in the fall, will provide a scholarship for one student out of each medical class.

Recipients will be selected according to their financial needs, and the amount of each grant will depend on a budget worked out by Roy K. Jarecky, M.D., associate dean for admissions at the medical school. The UK Medical School is one of 11 in the U.S. and Canada to participate in the program.

$9.7 Million Grant Presented To UL Medical School

A federal grant of 9.7 million dollars was issued August 3, 1966 to the University of Louisville Medical School to begin work on the new $24.8 million medical and dental school buildings. The grant, from the Department of Health, Education and Welfare, brings total federal funds for the project to $12.4 million.

Construction on the buildings will begin during the summer of 1967, and is scheduled to be completed by September, 1969. The new facilities will consist of a medical-dental complex in the proposed Medical Center of downtown Louisville, plus two other buildings, a medical library and a faculty research tower.

The new facility will take the place of the old medical and dental school buildings where conditions are crowded. The buildings will also permit a significant increase in enrollment for the two schools.

The annual meeting of the American Academy of Forensic Sciences will be held February 20-25, 1967 in Honolulu, Hawaii, at the Princess Kaiulani Hotel. The academy encompasses the disciplines of toxicology, pathology, psychiatry, questioned documents, criminalistics and forensic jurisprudence. It was founded in 1948 to centralize the various disciplines of the forensic sciences and to develop and extend better understanding of the application of legal doctrines to scientific professions.

Ray A. Cave, M.D., Leitchfield, reported August 1, at Fort Sam Houston, Texas for service in the U.S. Army. Doctor Cave, a 1960 graduate of the University of Louisville School of Medicine, has been a general practitioner in Leitchfield for the past five years.



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Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

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Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

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NEWS ITEMS

C. William Rogers, M.D., Madisonville, has joined the staff at Trover Clinic in June, for the practice of radiology. A 1955 graduate of the University of N.C. Medical School, Doctor Rogers interned at the U.S.N. Hospital, Charleston, S.C., and served his residency at the U.S.N. Hospital, Bethesda, Md., and at the University of Chicago in radiology. From 1955-1964, he also served in the U.S. Navy.

Emery E. Lane, M.D., Whitesburg has been added to the staff at The Daniel Boone Clinic in June. Doctor Lane is a 1964 graduate of the University of Louisville Medical School. He served his internship and residency at the Louisville General Hospital during 1964-66.

Carroll M. Steinfeld, M.D., Providence is now practicing in association with Trover Clinic as of July 1, 1966. Doctor Steinfeld is a 1963 graduate of the University of Louisville School of Medicine. He served his internship at the Philadelphia General Hospital and for the past two years, he has been in the U.S. Air Force.

Yasuo Sasuki, M.D., who lives in Cincinnati, has opened an office in Newport in June. Doctor Sasuki, who previously practiced in Covington, graduated from the University of Cincinnati Medical College in 1941. He began his general practice in 1942, after serving his internship in Covington.

Richard Albert Blair, M.D., Paducah, has recently begun practice in association with **O. Leon Higdon, M.D., Harold D. Priddle, M.D.,** and **Charles J. Bohle, M.D.,** all of Paducah. Doctor Blair, whose practice is limited to obstetrics and gynecology, is a 1959 graduate of the University of Louisville School of Medicine. He interned at the Ss. Mary and Elizabeth Hospital, Louisville, and served his residency at St. Joseph Infirmary and Louisville General Hospital. During the years 1961-1963, Doctor Blair served as a Captain in the U.S. Army Medical Corps.

Kenneth S. Welsh, M.D., former Rowan County Health Director, has resigned to take specialized training at Johns Hopkins in Baltimore. Doctor Welsh is a 1963 graduate of the Western Reserve University School of Medicine, Cleveland.

Anthony Flandina, M.D., recently retired chief house officer of the Central Baptist Hospital, Lexington, was honored July 13 by the physicians, staff and employees, who paid him tribute for his ten years service there.

John F. Knox, M.D., Stanton, was honored at a testimonial dinner in July. Doctor Knox was presented with a bronze plaque in recognition of his service for 58 years in the medical profession. Until recent years, Doctor Knox, a general practitioner, was located in Mt. Sterling.

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Each tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Phenacetin	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

The patient can feel better while getting better. ACHROCIDIN brings the treatment together in a single prescription—prompt symptomatic relief together with early, potent control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract.

Contraindication—History of hypersensitivity to tetracycline.

Warning—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.

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WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts, hepatic and renal function tests during intermittent or chronic use.

PRECAUTIONS: Succinylsulfathiazole: Use with caution if there is history of significant allergies and/or asthma. Continued use requires supplementary vitamins B_1 and K. *Neomycin:* Watch for

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curare-like neuromuscular block during anesthesia if neomycin is used preoperatively in large doses when renal function is poor; watch for overgrowth of nonsusceptible organisms. Consider possibility of ototoxicity and nephrotoxicity with prolonged high dosage.

SIDE EFFECTS: As with all sulfonamides: Headache, malaise, anorexia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, rash, conjunctival and scleral injection, petechiae, purpura, hematuria, and crystalluria have been noted. Reduced fecal output of thiamine and decreased synthesis of vitamin K have been reported. *Neomycin:* Nausea, loose stools.

Before prescribing or administering, read package circular with product or available on request.

promptly relieves diarrheal distress

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ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

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where today's theory is tomorrow's therapy

In Memoriam

JOSEPH M. WITHERS, M.D.
Cynthiana, Ky.
1934-1966

Joseph M. Withers, M.D., general practitioner from Harrison County, was killed, in July in the crash of his private plane near Jacksonville, N.C. Doctor Withers, a 1960 graduate of the University of Louisville School of Medicine, was a member of the Kentucky Medical Association, and of the American Academy of General Practice. Only a few days previous, he had announced his induction into the Armed Services.

GEORGE FIELDING JONES, M.D.
Henderson, Ky.
1890-1966

George Fielding Jones, M.D., Henderson, died on August 10. A retired general practitioner and general surgeon, Doctor Jones graduated from the University of Louisville School of Medicine in 1912. He was 76 years of age.

PAUL EMIL KERKOW
South Fort Mitchell, Ky.
1884-1966

Paul E. Kerkow, M.D., 81, a retired general practitioner who served northern Kentucky for half a century, died July 11, 1966, of a coronary thrombosis. Doctor Kerkow, who received his medical degree in 1907 from the Pulte Medical College, Cincinnati, was widely known as the founder of the Spence Kerkow Memorial Golf Tournament, in honor of his son.

Sponsors Essay Contest

The Central States Society of Industrial Medicine and Surgery has announced a contest, open to all medical students, interns or residents, on any subject concerning occupational health. Winners, to be judged after the contest closes at midnight, December 31, 1966, will receive a $250.00 award. The criteria will be based on clarity, validity, objectivity, originality and style. Contest rules may be obtained from: Industrial Medical Association, 55 East Washington St., Chicago, Ill, 60602.

"The Measurement of Depression" is a 22 minute film depicting the development, validation, and use of a scale for the quantitative measurement of depression. The film is designed for medical educational purposes at meetings of hospital staffs, county societies or specialty groups. Designed by psychiatrist, William W.K. Zung, M.D., Durham, N.C., the scale was initially devised for use in psychiatric research, but it is also used in the general practice of medicine where most depressions are first encountered. Both the film and pads of the self-rating scale are available free upon request from Lakeside Laboratories, Inc., Milwaukee, Wisc.

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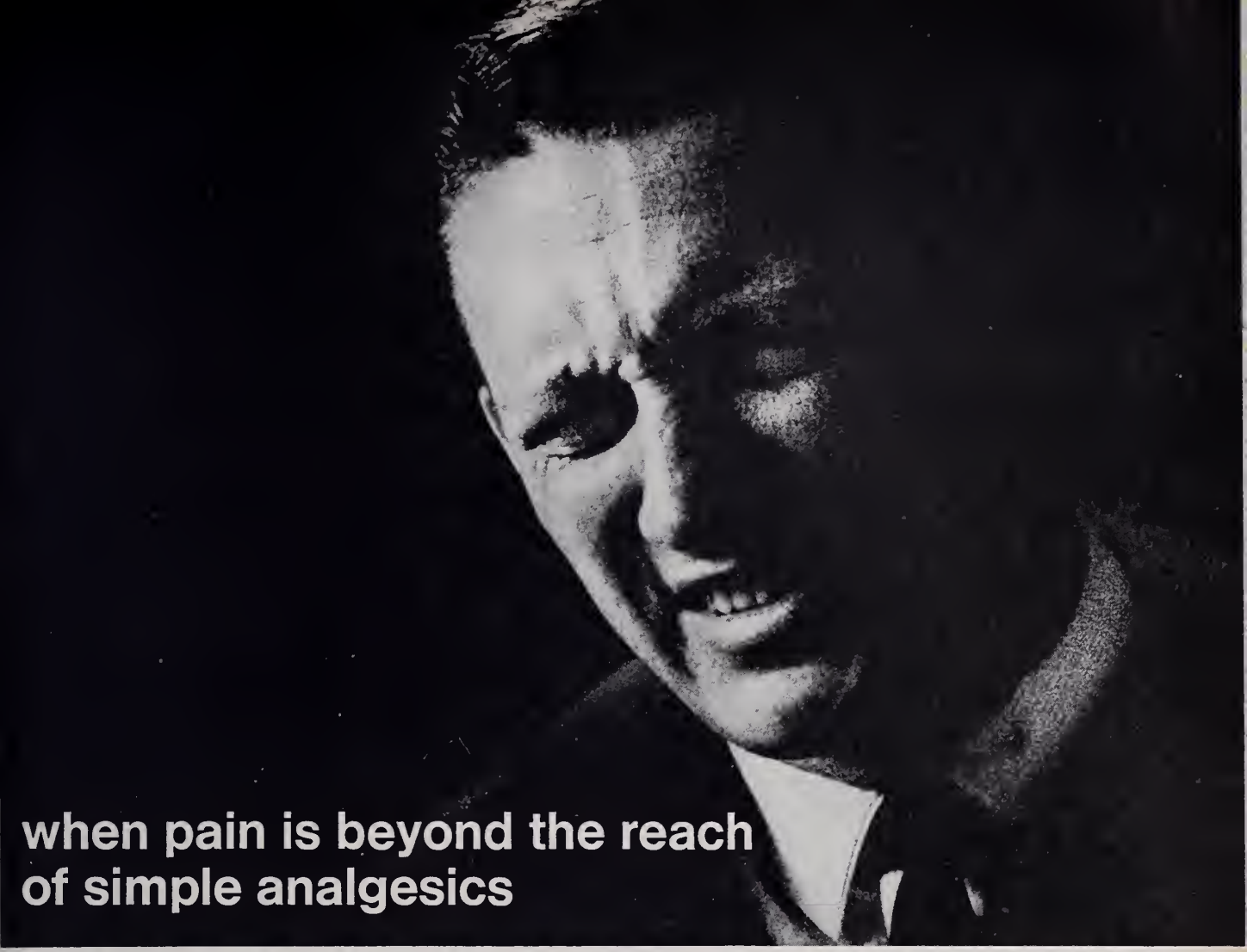
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chlormezanone 100 mg. with aspirin 300 mg.

subdues the major contributors to pain:

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- mental tension
- muscle tension-spasm

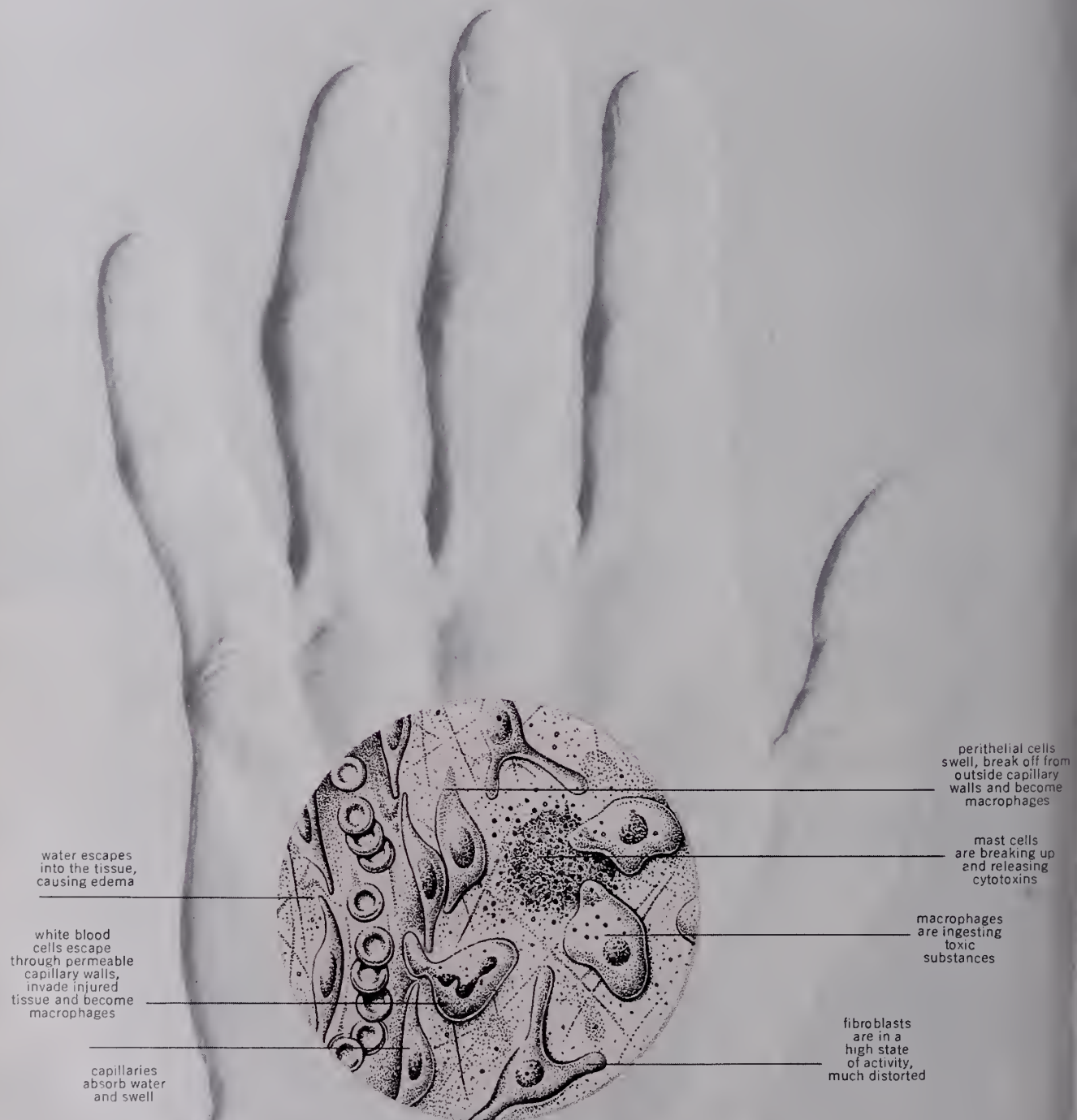
TRANCO-GESIC is so well tolerated it can be prescribed for anyone who can take aspirin. It is non-narcotic, and free from dangers of addiction, habituation, or dependence. TRANCO-GESIC is effective in all types of mild and moderate pain. Of 862 patients who were treated with chlormezanone and aspirin for various disorders, 88% reported excellent or good pain relief.[1]

Side effects have been minor. Occasionally gastric distress, weakness, sedation or dizziness occur. Reversible cholestatic jaundice has been reported on rare occasions. However, in 4,653 patients treated with chlormezanone, 97.7% had *no* side effects.[1] *Contraindication:* just one: sensitivity to aspirin. *Dosage:* Adults, usually 2 tablets three or four times daily. Children (from 5 to 12 years), 1 tablet three or four times daily.

1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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*A New View of Corticosteriod Action in Inflammatory Dermatoses
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(fluocinolone acetonide)

stabilizes cell and capillary walls
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interrupts the chain reaction of destructive changes at the cellular level

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In inflammatory dermatoses choose a steroid synthesized specifically for topical use. Synalar (fluocinolone acetonide) provides therapeutic results often comparable to those of systemic and intralesional corticosteroids with fewer hazards.[1-3]

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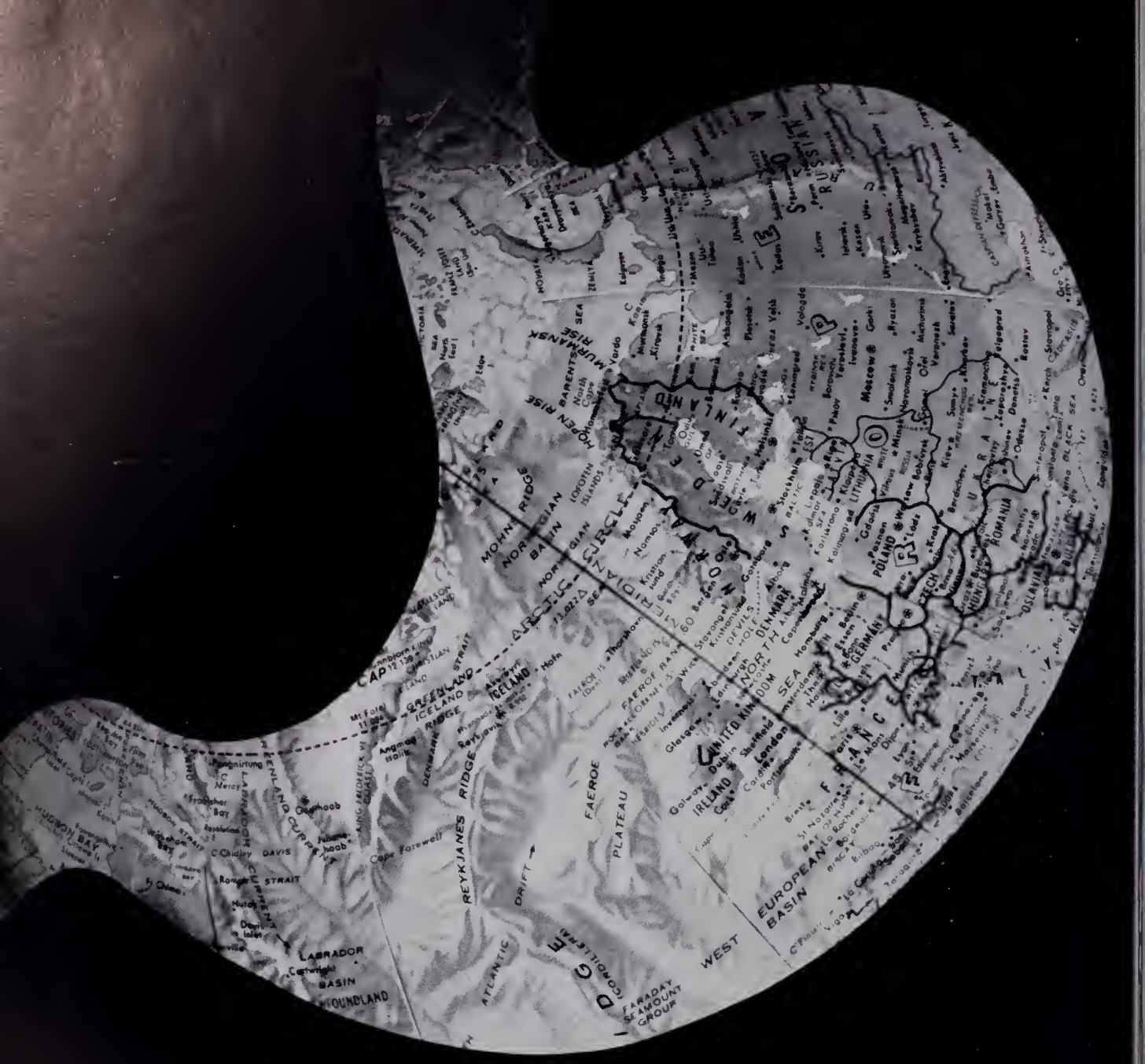
For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; **for emollient effect:** Ointment 0.025%, 15 Gm. tubes; **for maintenance therapy:** Cream 0.01%, 15 Gm. tubes, 45 Gm. tubes, 120 Gm. jars; **for intertriginous or hairy sites:** Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; **for infected inflammatory dermatoses:** Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. The neomycin in Neo-Synalar Cream rarely produces allergic reactions. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

References · **1.** Kanee, B.: Canad Med Ass J 88:999 (May 18) 1963. **2.** Scholtz, J. R.: Calif Med 95:224 (Oct.) 1961. **3.** Jansen, G. T., Dillaha, C. J., and Honeycutt, W. M.: Arch Derm 92:283 (Sept.) 1965.

fluocinolone acetonide—an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.



The "Socio-geographic" mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.[3-8] Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."[3]

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action confirmed by gastric analyses and x-ray evidence of clinical effectiveness.[3,7,9-12] Relieves pain with "impressive" promptness.[8] Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, belching and other ulcer symptoms.[7] Suppression of nocturnal pain is "outstanding."[13] Maximally effective doses may be given with minimal side reactions, and the incidence of unwanted anticholinergic effects is negligible.[3,7-14]

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Robinul®
(glycopyrrolate)

promotes the essential ulcer-healing environment

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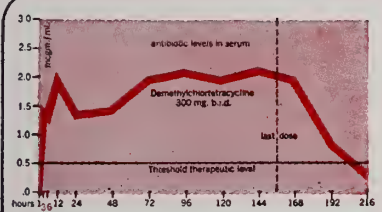
promotes the essential ulcer-healing environment

Indications: In addition to its primary indications for duodenal and gastric ulcer, Robinul (glycopyrrolate) is indicated for other GI conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.
Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.
Precautions: Administer with caution in the presence of incipient glaucoma.
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.
Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*
Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.
References: **1.** Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. **2.** Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. **3.** Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. **4.** Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. **5.** Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. **6.** Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. **7.** Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. **8.** Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. **9.** Epstein, J. H.: Ibid 37:295 (Mar.) 1962. **10.** Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. **11.** Slanger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. **12.** Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. **13.** Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. **14.** Fleshler, B.: J New Drugs 2:211 (Jul.-Aug.) 1962. **A. H. ROBINS CO., INC.**
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greater potency
lower mg intake per day
600 mg versus 1,000 mg

in G.U. infections
broad-spectrum performance



high activity

From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M.: Amer. J. Med. Sci. 243:296 (Mar.) 1962

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

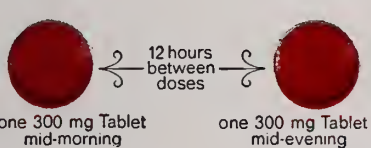
Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

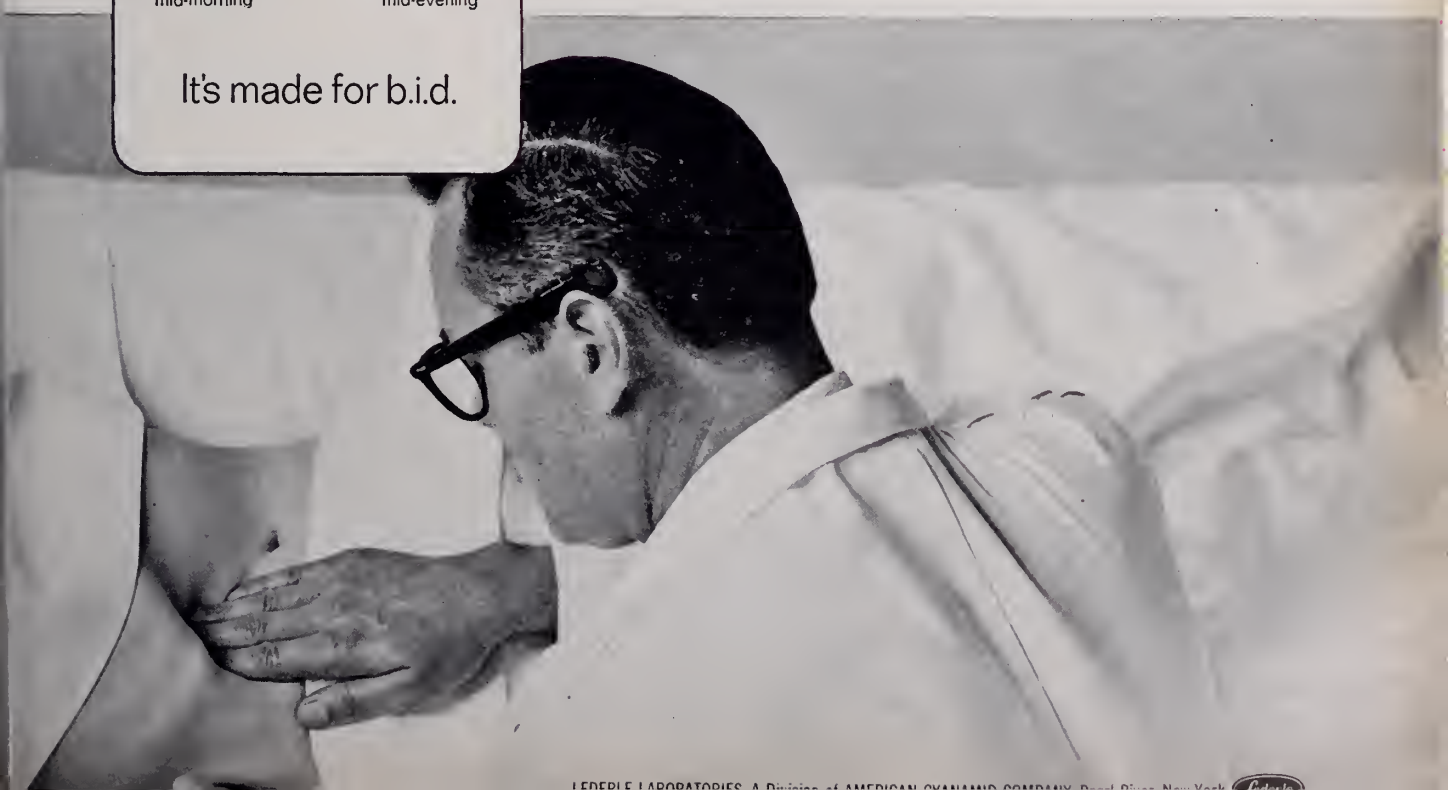
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after the last dose to protect against relapse



one 300 mg Tablet
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QUESTION: How will Blue Cross-Blue Shield members be billed when one family member is under 65 and the other is over 65?

ANSWER: *Separately, one for regular Blue Cross-Blue Shield, the other for "Blue Cross-Blue Shield 65". Blue Cross and Blue Shield will make the necessary conversion to provide all eligible dependents with continuous coverage.*

QUESTION: What happens to Blue Cross-Blue Shield members who reach age 65 after July 1, 1966?

ANSWER: *If they are direct pay members, a notice will be sent to them with an application to transfer to "Blue Cross-Blue Shield 65".*
It is necessary for groups to contact Blue Cross-Blue Shield regarding their employees or retires on the group plan who reach age 65.

QUESTION: May persons who are not Blue Cross-Blue Shield members who reach 65 after July 1, 1966, apply for "Blue Cross-Blue Shield 65"?

ANSWER: *They may apply within 60 days before to 30 days after reaching age 65, and will be accepted if they meet health requirements. A $2.00 enrollment fee will be required.*

QUESTION: Is there any waiting period for Blue Cross-Blue Shield members transferring to "Blue Cross 65"?

ANSWER: *No.*

QUESTION: Does a person accepted for "Blue Cross-Blue Shield 65" who was not already a Blue Cross-Blue Shield member have any waiting period for pre-existing conditions?

ANSWER: *Yes. Six months from effective date for pre-existing conditions whether known or unknown prior to effective date.*

QUESTION: Can "Blue Cross-Blue Shield 65" be transferred from one Plan area to another?

ANSWER: *No. Each Plan will bill these members regardless of the area in which they live.*

QUESTION: What are the dues for "Blue Cross-Blue Shield 65"?

ANSWER: *Rates are $5.00 per month, per member. Nongroup (direct pay) members will pay quarterly; group members monthly.*

QUESTION: Will there be any family contracts for Blue Cross-Blue Shield 65"?

ANSWER: *No. To make the adjustment to "Blue Cross-Blue Shield 65" a husband and a wife must each complete an application to transfer to two single contracts.*

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The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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Wallace Laboratories, Cranbury, N.J.



brings peace to the hyperactive colon

CANTIL®
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helps restore normal motility and tone

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IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



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Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

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Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

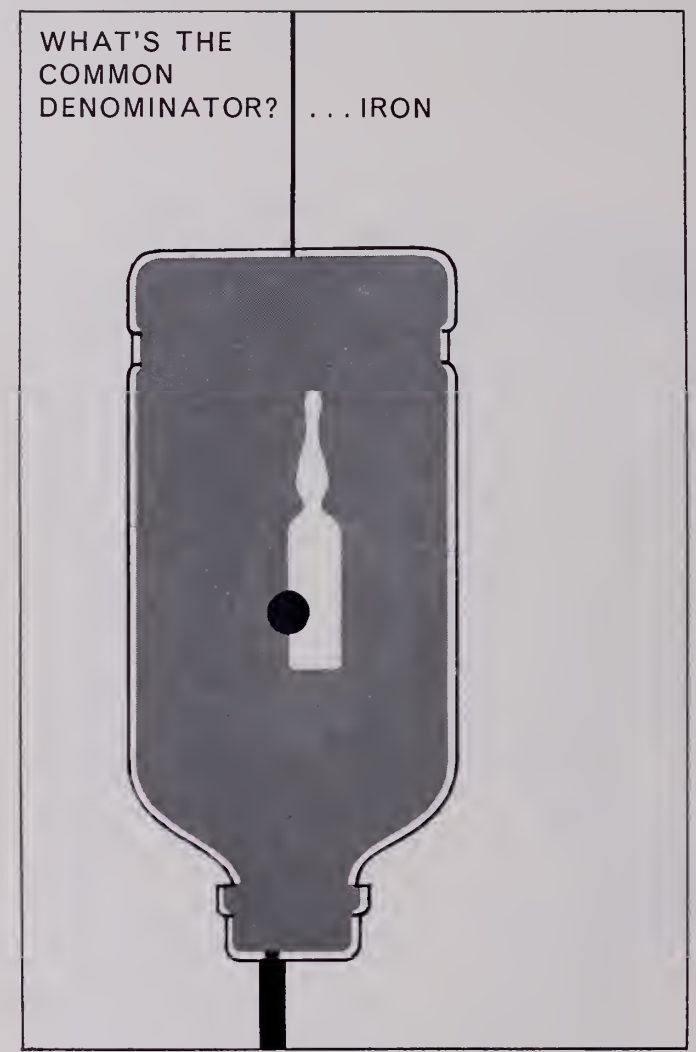
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(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

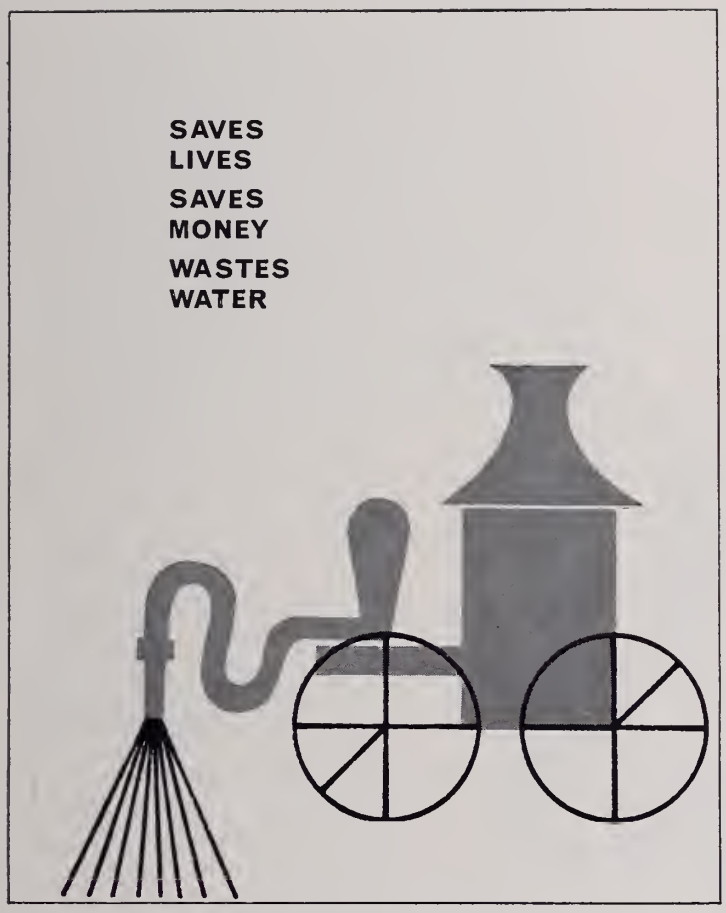
CARCINOGENICITY POTENTIAL: Using relatively massive doses. Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

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this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

Barry Belonsky, M.D., F.A.C.A.
Staff Anesthesiologist, Hospital of The Albert Einstein College of Medicine, New York City



Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care requiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.[1] In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out",[2] a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.[3]

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result from secretions penetrating the bronchi and bronchioles. In laryngospasm, there are both inspiratory and expiratory stridor and difficulty in inflating the chest; in bronchospasm there is an expiratory wheeze, but not as much difficulty in inflation, although some resistance may be felt. Stridor is due to partial or complete closure of the vocal cords in spasm and the "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produces *difficulty in ventilation* through the mouth until the patient is deep enough to place an oral airway. An intravenous agent can be given to facilitate the induction of anesthesia.

Difficulties can arise if intubation is performed to ventilate the patient. For example, teeth can be broken by too vigorous attempts at intubation, or the intubation itself may be technically difficult due to secretions obstructing the view of the glottis. The postoperative sequelae of intubation ranges from mild laryngitis to pneumonia with atelectasis, and are seen far more commonly in patients suffering from colds than in normal patients.



Successive stages of laryngospasm which produce the characteristic stridor or "crowing" sound.



Progression of bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intra-anesthesia complications, and occur much more frequently in a patient who has been intubated.[4]

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment[5,6,7,8] consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

(concluded on following page)



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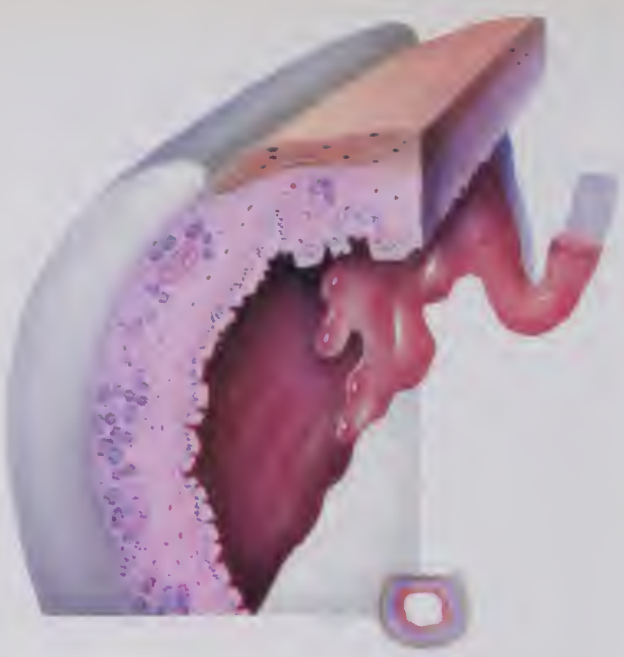
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Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions become more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary: Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

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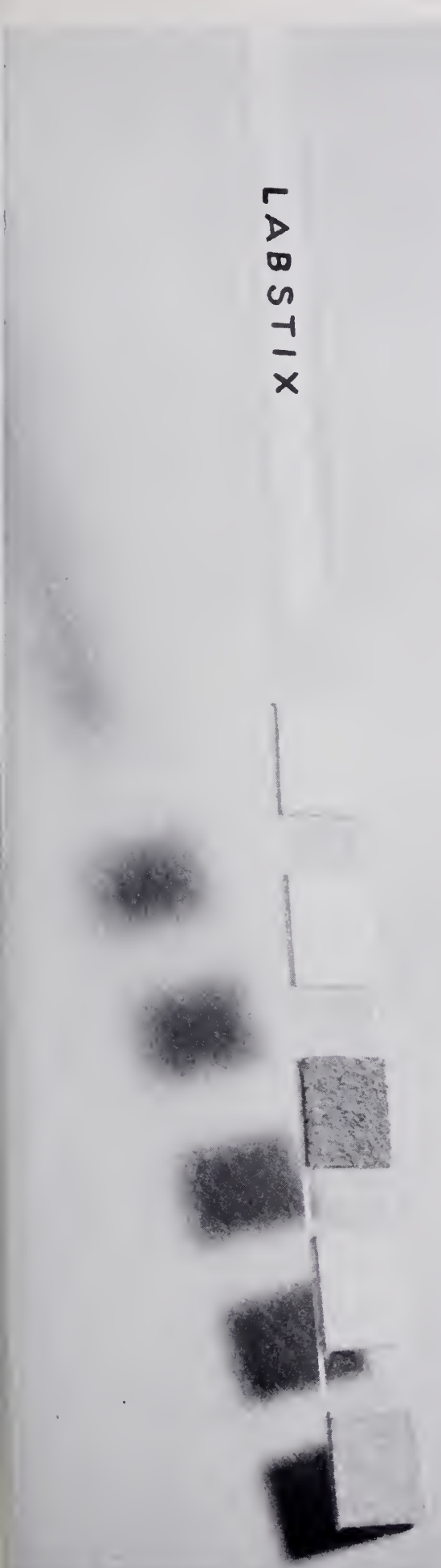
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Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

Dosage: *Oral*—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

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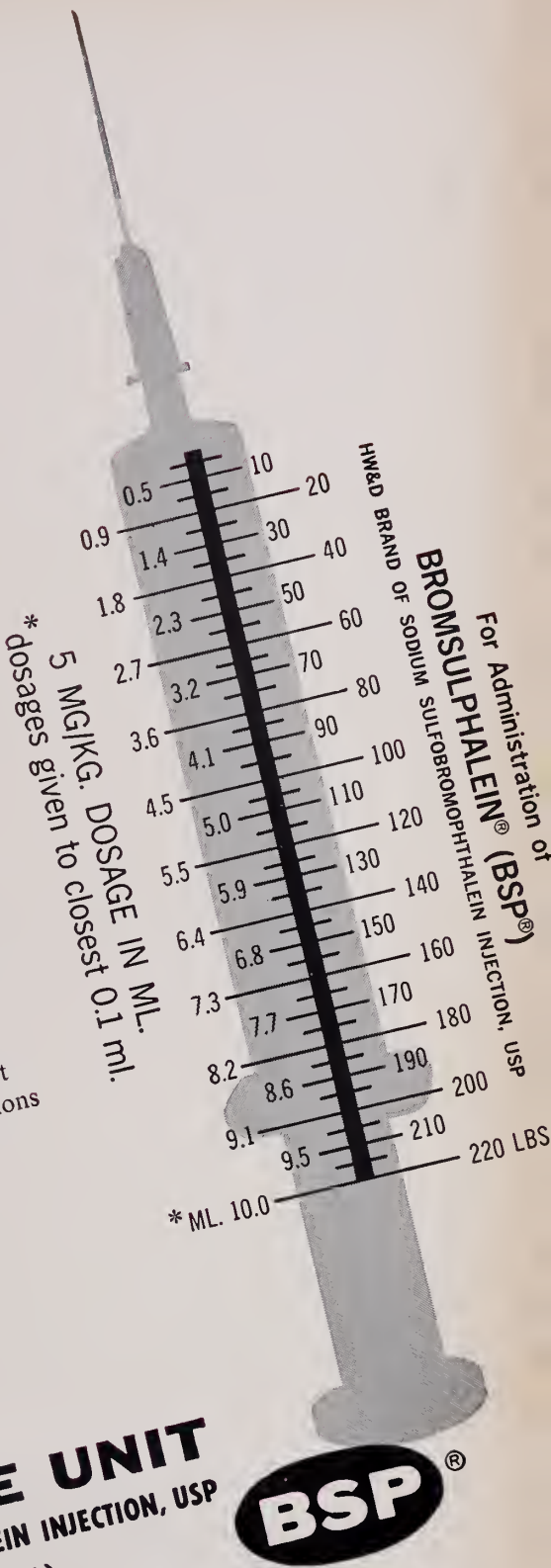
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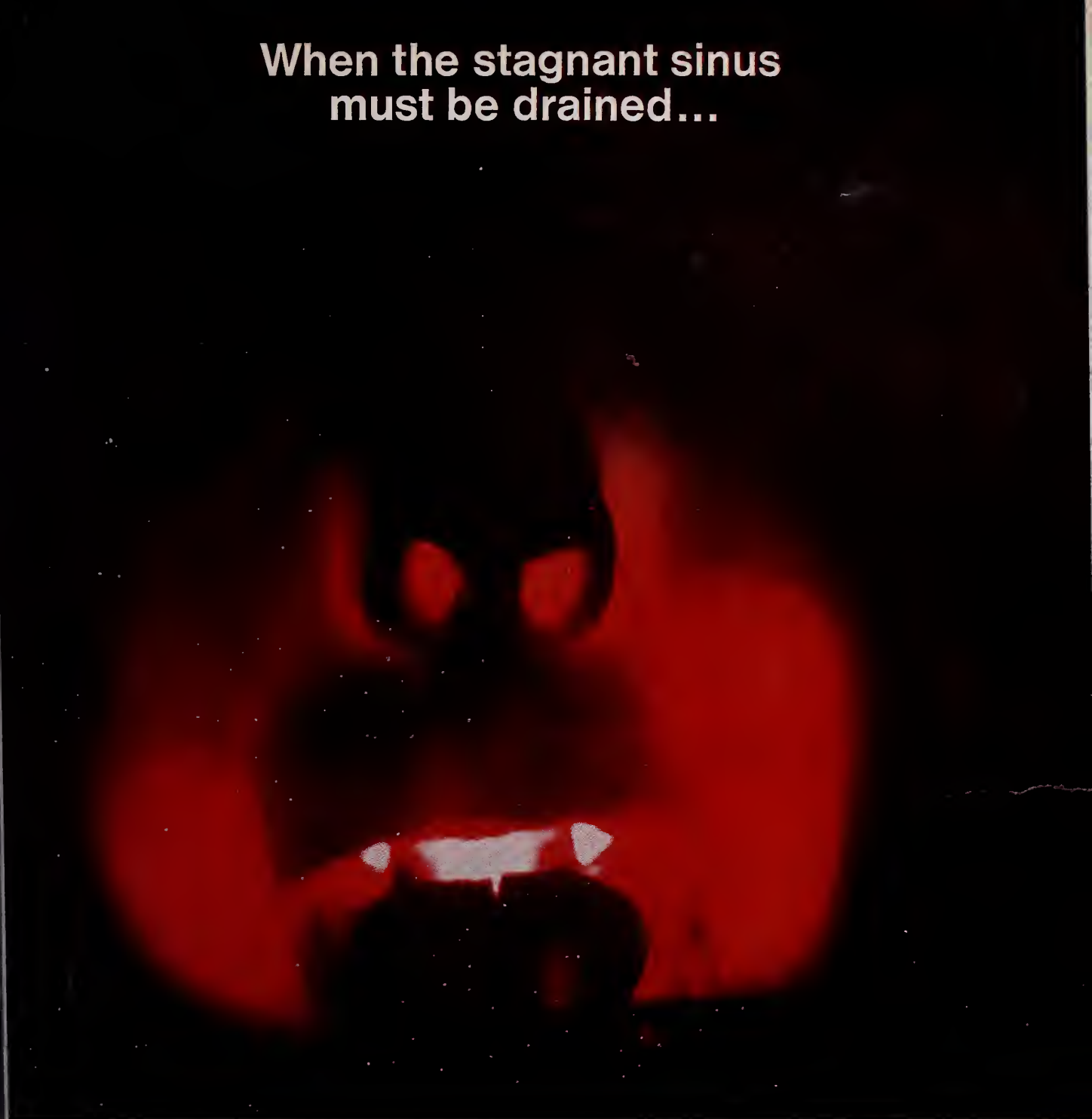
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When the stagnant sinus must be drained...



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When blood pressure won't stay down despite initial therapy—when complaints of headache, fatigue or dizziness are often voiced—it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine *plus cryptenamine*—a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

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MESSAGE FROM THE PRESIDENT



DURING the annual meeting of the AMA in Chicago I had the privilege of hearing a group of young college students who had given a year of their lives traveling over the United States, and the world, as a singing group called "Sing Out 66". They gave a very enthusiastic and entertaining program based around a theme of patriotism and our American heritage.

Recently they appeared on a national television program and having been so impressed with them before, I listened again. The finale of their program was a song entitled "Freedom Isn't Free". While listening, and frequently since, I could not but reflect how this subject applied to medicine today.

Some of our freedom has been recently curtailed by the biggest step in our history of governmental participation in medicine. This was a disappointment to the majority of our profession as they feel it is the "foot in the door" to further domination of private physicians by governmental bureaucracies. But this step is only trivial compared with the restraints placed on our colleagues in other countries and are planned for us by some of the more militant left-wing.

Some physicians blame their leaders in the local, state, and national organizations for this legislation. Some talk of withdrawing from these societies, deeming them ineffective and their dues a waste of money. If one does not agree with his society, more can be accomplished by working within an organization than being outside and unfamiliar with its policy and activity.

There are many other activities in which these medical organizations participate besides socioeconomic. The best way to tear them down and bring on total and complete domination of private medicine would be by passive resistance and resignation of defeat. This is a time for further dedication of our ideals of providing the best medical care for the most people without third party intervention.

No, freedom isn't free. You can't buy it, as many ineffective governmental programs will attest. You can attain it by a cohesive effort, by diligence, hard work, and having an objective attitude toward unsolved medical problems.

Robert E. Pennington



Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

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When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials — usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

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CONTRAINDICATIONS: Do not use in intestinal obstruction, extensive ulceration of bowel, or diverticulosis; in hypersensitivity to sulfonamides or neomycin; in pregnancy at term, in premature infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts, hepatic and renal function tests during intermittent or chronic use.

PRECAUTIONS: Succinylsulfathiazole: Use with caution if there is history of significant allergies and/or asthma. Continued use requires supplementary vitamins B_1 and K. *Neomycin:* Watch for

your ℞ for Cremomycin can provide relief



curare-like neuromuscular block during anesthesia if neomycin is used preoperatively in large doses when renal function is poor; watch for overgrowth of nonsusceptible organisms. Consider possibility of ototoxicity and nephrotoxicity with prolonged high dosage.

SIDE EFFECTS: As with all sulfonamides: Headache, malaise, anorexia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, rash, conjunctival and scleral injection, petechiae, purpura, hematuria, and crystalluria have been noted. Reduced fecal output of thiamine and decreased synthesis of vitamin K have been reported. *Neomycin:* Nausea, loose stools.

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Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

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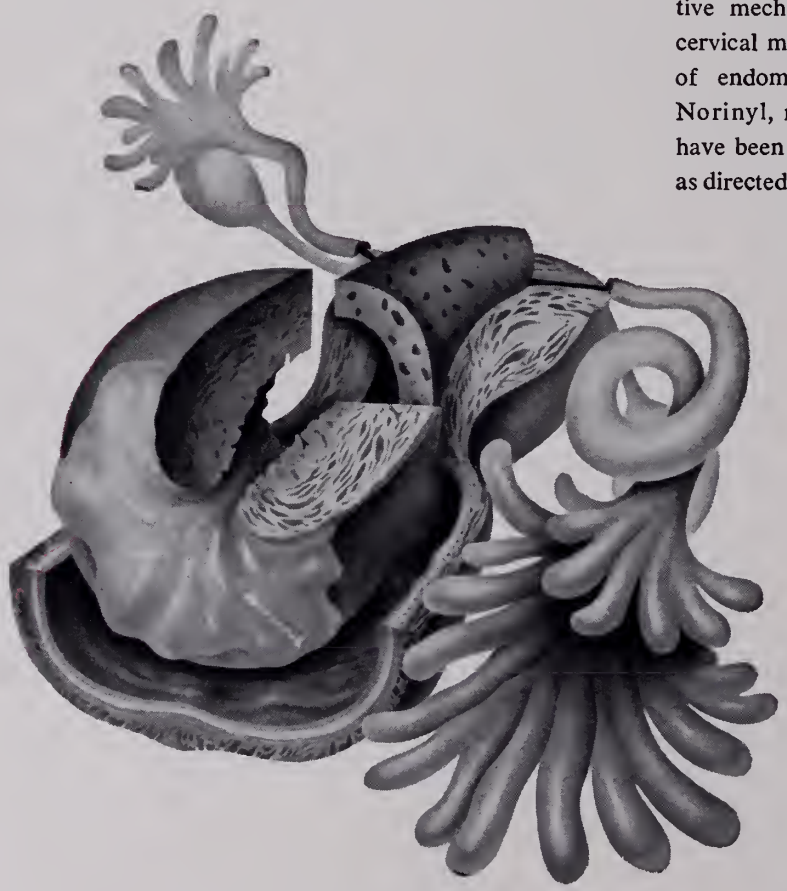
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for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation



no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

plus important supportive benefits that help her through those critical early months of oral contraception

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An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: **1.** Council on Drugs. JAMA 187:664 (Feb. 29) 1964. **2.** Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. **3.** Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. **4.** Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. **5.** Hammond, D. O.: Ibid. **6.** Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. **7.** Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. **8.** Kempers, R. D.: GP 29:88 (Jan.) 1964. **9.** Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. **10.** Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. **11.** Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. **12.** Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. **13.** The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. **14.** Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. **15.** Merritt, R. I.: Appl Ther 6:427 (May) 1964. **16.** Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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for multiple contraceptive action



CURRENT DIAGNOSIS: edited by Howard F. Conn, M.D., Robert J. Clohecy, M.D., and Rex B. Conn, Jr., M.D.; Published by W. B. Saunders Company, Philadelphia, and London, 1965; 843 Pages; Price, $19.00

The most capable clinicians are as much distinguished by their ability to organize their knowledge and experience effectively as by their erudition or store of clinical details. A book devoted to an explication of the diagnostic approaches employed by seasoned clinicians in difficult problems would be a valuable addition to any physician's library.

Unfortunately, the attempt to achieve this desirable end in this book does not succeed. The editors have set for themselves the formidable task . . . of assisting the physician "when he has a problem" and when confronted with ". . . the puzzling and confusing variations of the clinical picture rather than the classical textbook image of the disease." To this end almost 300 authors have contributed articles varying in length from a few paragraphs to more than thirty pages. These purport to set out the precise steps essential to confirming the diagnosis of most of the disorders covered in textbooks of medicine.

The articles are contributed by capable clinicians, many of whom are well recognized authorities. Only a few fulfill the editor's expectations however. Most of the contributions turn out to be condensed versions of what can be found in the standard textbooks, usually not as well presented. The subjects range from the trivial to the most complex. While important, one can hardly classify such things as otitis externa, hay fever, hemorrhoids and osteoarthritis for example, as complex diagnostic problems. One suspects the contributors were at times a bit bored with the repetition of what is well-known or should be.

Some articles are so briefly presented as to be meaningless and others like the one on congenital heart disease strive for completeness but without selection of what constitutes the major problem in diagnosis. All the articles assume that the clinician has a diagnosis in mind and wishes to see whether or not he has sufficient criteria for its diagnosis. Some are little more than a disconnected enumeration of signs, symptoms and laboratory tests. References are not provided. Critical comments on diagnostic methods, new insights into clinical signs and orderly approaches to major presenting symptoms are disappointingly infrequent.

For this reviewer, it is difficult to see how the book adds to what the better textbooks of medicine already provide, except the guarantee of a biennial revision. While the goal is a desirable one, it is doubtful whether 300 authors can divulge the ". . . wondrous cognitive process . . ." of clinical diagnosis in such a series of prescriptions and prescriptions. Perhaps, in future revisions, both the number of authors, and topics, will be drastically reduced and truly difficult diagnostic problems discussed fully and critically.

The editors are right in sensing the need for a critical evaluation of the diagnostic process seen through the eyes of mature clinicians. They have chosen an unfortunate and essentially unmanageable way of doing this. A book of this type, to be coherent, would need far more editing than this one evidences. The result is a handbook of diagnostic criteria which will be useful to some students and practitioners, chiefly to refresh their memories.

Prospective buyers should dip into this book themselves before buying. It may be what they are seeking. The chances are most readers will want something more substantial and sophisticated if they really have a complex diagnostic problem before them.

EDMUND D. PELLEGRINO, M.D.

SYMPOSIUM ON SURGERY OF THE OCULAR ADNEXA: by the New Orleans Academy of Ophthalmology; published by the C. V. Mosby Company, Inc., St. Louis, Mo.; 1966; 245 pages; 116 illustrations; $16.

This book is a compilation of the lectures given at the Fourteenth Annual Session of the New Orleans Academy of Ophthalmology in February of 1965.

The contributors are: Arthur Gerard DeVoe, M.D.; Sidney A. Fox, M.D.; Howard Naquin, M.D.; T. E. Sanders, M.D.; Byron Smith, M.D.; Everett R. Viers, M.D.; and Joseph A. C. Wadsworth, M.D. All are outstanding ophthalmologists who relate their personal experience in the handling of different and difficult ocular adnexal problems. Etiology and diagnosis are also discussed.

Topics covered include: 1. Corrective surgery for lid conditions such as burns, ptosis, entropion, and colobomas; 2. Diagnosis and treatment of lacrimal system diseases including a chapter in dacryocystography; and 3. nonsurgical and surgical treatment of tumors of the lids and orbit. A chapter on the pathology of these tumors is given. The round table discussion is excellent.

The book reads easily and the illustrations are excellent. A complete coverage of each disorder is concisely presented. This book is highly recommended for all who are interested in this highly specialized field of surgery.

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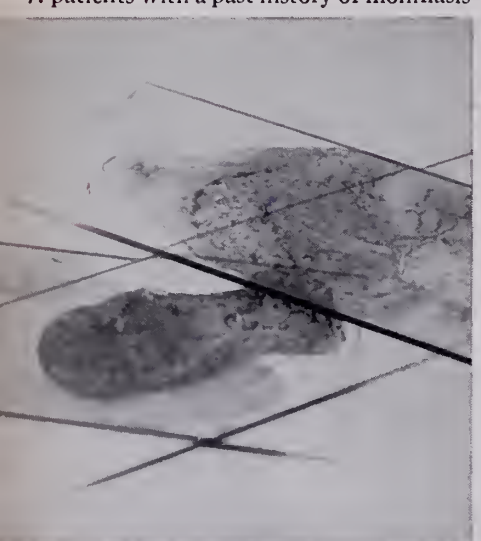
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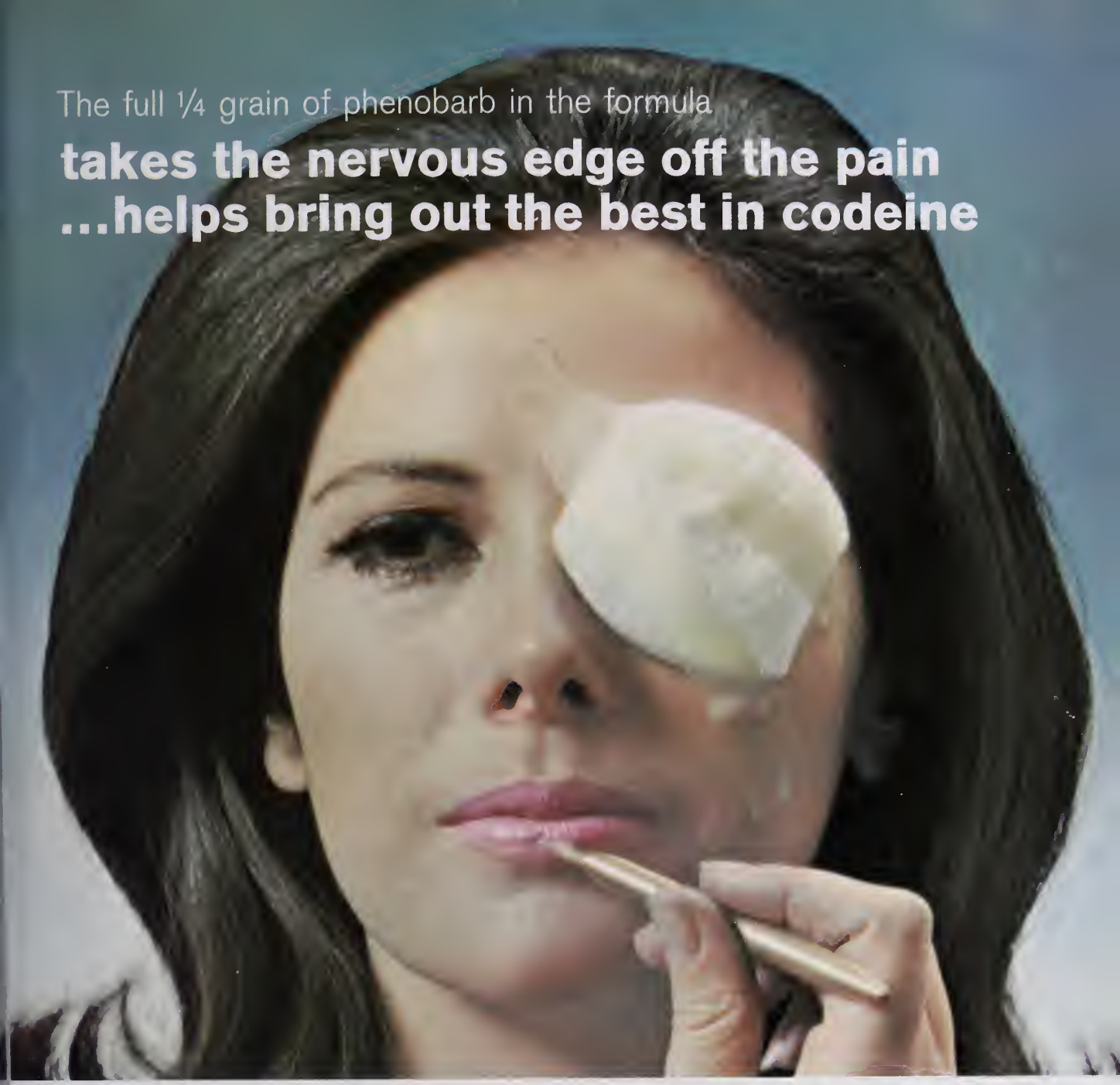
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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Morcover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

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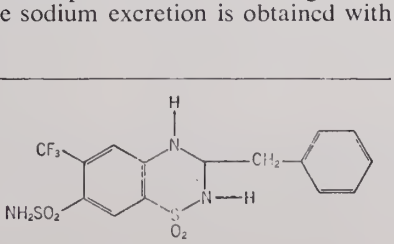
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

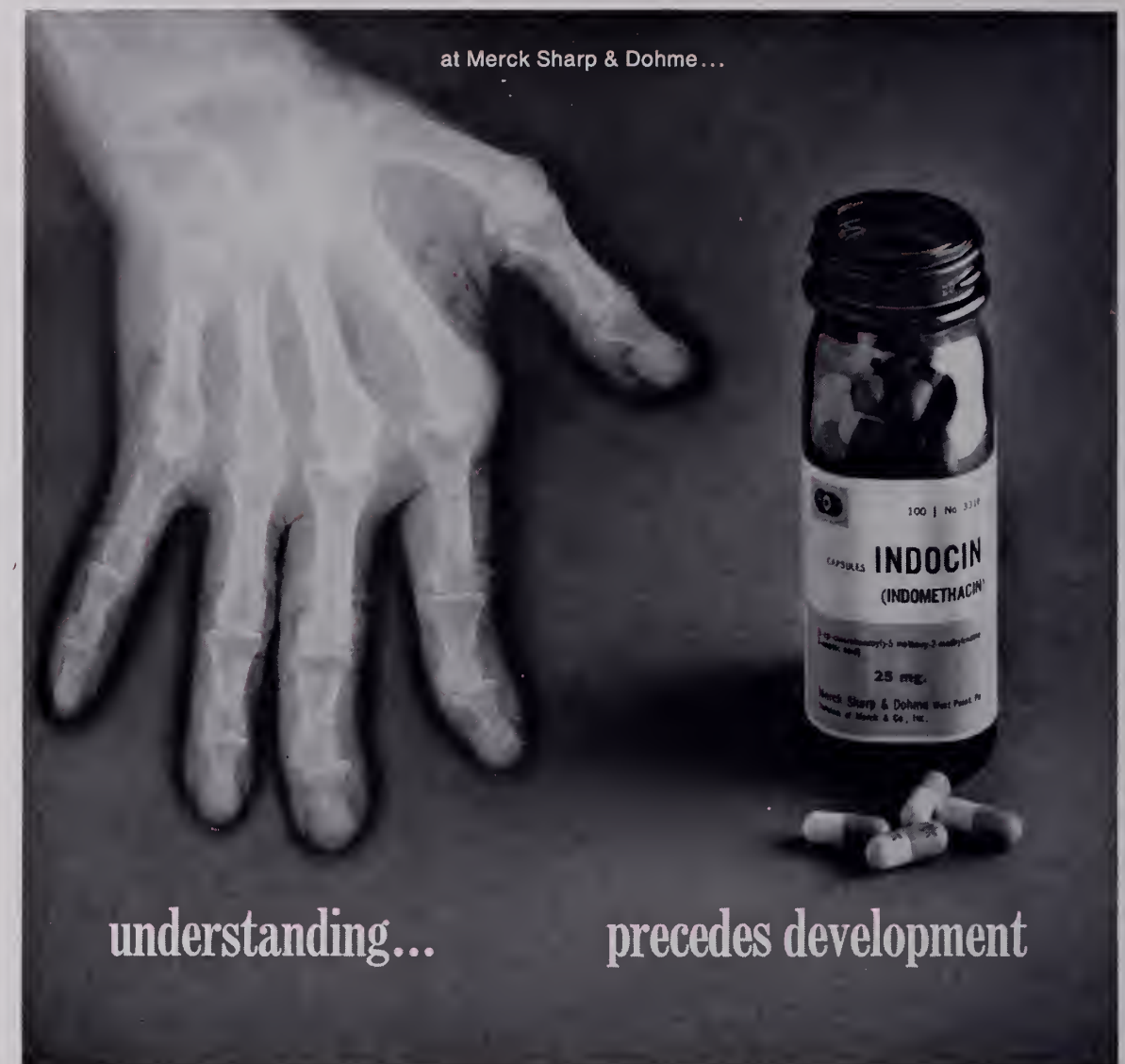
Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

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References: 1. Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.
Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.
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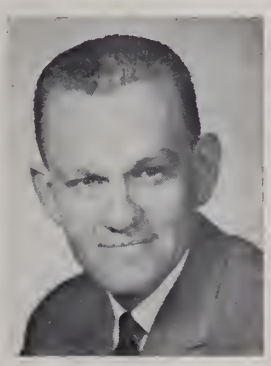
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Symposium on Blood Transfusion

Ellis A. Fuller, M.D., Guest Editor
Louisville, Ky.

THE procurement and proper use of blood products has become a subject of compelling concern in recent years. Since blood products must be obtained from living human donors, problems of supply cannot be solved by legislation or mass production. When transfusion is required, not only must the primary medical indication be considered, but also proper use requires evaluation of cardiovascular physiology, hepatic and renal status, and knowledge of the bone marrow function and adequacy of the hemostatic mechanisms.



Doctor Fuller

The dangers which are inherent in any transfusion are markedly compounded by human error and improper use of blood. When immunologic incompatibilities are present, expert knowledge and painstaking investigation are required to make an intelligent decision about any use of blood products. Recent litigation procedures have emphasized the increasing importance of the medicolegal aspects of transfusion responsibility.

It is important that each physician involved in the administration of blood or blood products understand his area of responsibility, and have adequate knowledge about both the proper use and the dangers involved. Transfusion problems require a unique cooperation between the blood procurement service, the laboratory, and the responsible physician to insure optimal use of the available blood. Because of the special moral, ethical, medical and legal problems associated with the use of blood, transfusion review committees have been established at many hospitals to improve transfusion practices. Indeed, the whole subject has been considered of sufficient importance to merit this special symposium in *The Journal of the Kentucky Medical Association.*

Whole blood transfusion is a tissue transplant in the truest sense of the word, for living cells from one individual must be given to another in the living state. It is the most successful and widely used transplant because of the ease of obtaining and transferring a blood sample, the relatively simple metabolic requirements of the red cells, and because a temporary function is frequently all that is needed to sustain life over a critical period.

The blood tissues make up the largest and most active organ in the body. Blood serves primarily as a transport system which maintains a constant supply of oxygen, essential nutrient materials, coagulation factors, white cells, platelets, hormones and antibodies to cells throughout the body. It is the vehicle for removal of carbon monoxide and waste materials, and is important in temperature regulation. Any significant compromise of these vital functions may lead to severe morbidity or death. Many disease states can and do interfere with one or more of these functions. In such situations, the supplying of a needed blood product from a normal individual may be life saving.

Practical and relatively safe transfusion of blood products is a rather new science. The initial experimental transfusion of animal blood intravenously into humans was first attempted in the seventeenth century shortly after Harvey described the blood circulation. Initial transfusion attempts were doomed to disaster until Landsteiner, Levine, Weiner and others early in this century discovered and recognized the fundamental importance of major blood groups in the matching of compatible blood types. The further development of anticoagulation, nutrient additives and refrigeration made stoarge of living cells possible. Based on these advances, the first blood bank established at Cook County Hospital in Chicago in 1937. Today an adequate transfusion service is a necessary cornerstone of any medical community. Such services not only provide for primary patient needs, but also make possible extensive surgical procedures, use of the artificial heart and kidney, and tissue transplantation.

Blood transfusion continues to be a rapidly changing science and will increase both in complexity and usefullness as further advances are made. Better methods of blood preservation may soon extend the dating period for banked blood. Recent research has given rise to hope for practical freezing of red cells. Use of the computer for inventory control should make possible better use of available blood supplies, and help in projecting future needs for blood procurement. Advances in processes of fractionation and purification of specific blood products will allow more patients to benefit from a single unit of blood.

The last twenty years have witnessed such a spectacular growth in the use of blood products that almost six million units were used in the United States in the last twelve months. The procurement of the vast quantities of blood needed to sustain the present transfusion program is a problem of great magnitude which has reached disasterous proportions in some sections of the country.

To maintain adequate volunteer donations —more than 80% of the supply is obtained from donors who receive no monetary gain— requires daily effort by many dedicated workers. All blood banking programs require a broad base of community support as well as the active interest of physicians and hospital personnel. Each patient who receives a blood product should be urged to have family and friends replenish the supply regardless of the blood procurement system. Insurance coverage or ability to pay is of little benefit since dollars can neither be transfused or buy sufficient blood to meet the needs.

It is the purpose of this symposium to bring together practical clinical information regarding the proper use of blood products. The first paper outlines basic principles for the use of whole blood and packed cells, and stresses the difference in the physiological management of acute blood loss as opposed to the problem of chronic anemia. Knowledge of the hazards of transfusion, and recognition and management of adverse reactions is of equal importance, and is discussed in the second article. The third paper reviews the important blood groups, laboratory procedures, proper handling of blood and discusses the problems produced by incompatible crossmatches. The fourth article is devoted to the increasingly important area of blood fractions. The final paper discusses the medicolegal responsibilities which should be clearly understood by all physicians using blood products.

Ellis A. Fuller, M.D.

Clinical Use Of Whole Blood And Packed Red Cells

ELLIS A. FULLER, M.D.*, CHARLES E. DOBBS, M.D.**, AND MARION F. BEARD, M.D.***
Louisville, Ky.

Introduction

THE largest number of patients that require transfusion products need erythrocytes present only in whole blood or packed red blood cells. There is no substitute for these products when the oxygen-carrying capacity of hemoglobin is needed. To sustain life, the intravascular compartment must contain an *adequate volume,* and the blood must have a *sufficient hemoglobin* concentration. However, there is a large functional reserve in both blood volume and oxygen-carrying capacity that will allow moderate reduction in one or both of these factors without significant morbidity. It is only when the limits of acceptable tolerance of one or both of these functions is reached that blood transfusions is indicated Because of the very real dangers that are inherent in transfusion, Col. William Crosby has aptly stated, "The major contra-indication to transfusion is the lack of a specific indication[1]."

Whole blood is primarily indicated in situations where there is acute loss of whole blood to the point that the cardiovascular system may not be able to maintain adequate perfusion so that the danger of hypovolemic shock develops. Packed cells are primarily indicated when the oxygen carrying capacity is decreased to the point that peripheral cellular anoxemia may occur because of a lowered hemoglobin. While there are situations in which both problems may be present in the same patient, it is important for the clinician to separate in his own mind the volume problems as opposed to the problem of anemia, since quite different patho-physiologic principles are involved. For reasons which will be outlined, whole blood should not be used if packed cells will supply the need, and neither should be used if a specific component, fraction, or other substance is available to supply the need.

The first section of this paper deals with acute blood loss, whole blood characteristics, and its use in the management of acute hemorrhage. The second section deals with the chronic anemias and the use of packed cells in management. Finally, the proper techniques of administration and certain special transfusion problems are discussed.

Transfusion for Volume Replacement

PATHOPHYSIOLOGY OF ACUTE BLOOD LOSS

The blood volume of the average man, calculated on the basis of weight, is 67.5 ml per kilogram of body weight[2]. Considerable variation exists, depending on such factors as sex (63 ml per kilogram in women), age (approximately 480 ml less after age 40), body build and obesity (fat is a relatively blood free tissue). For the average adult, this will mean between eight and fourteen pints of blood in the intravascular compartment. If approximately 40% of this volume is lost acutely, shock may supervene, and such blood loss is the prime indication for whole blood transfusion. In most individuals, 1000cc or approximately two pints can be lost acutely without difficulty. The loss of 500cc of blood is of no concern in the otherwise healthy individual. This fact, of course, makes the donation of a pint of blood for transfusion a safe and practical procedure.

If the blood loss is massive, replacement must be rapid (50-75 ml per minute), at times requiring a 15 gage needle, pressure, or even transfusions into two separate veins. If rapid transfusions are given, even the patient with a normal cardiovascular status has to be closely monitored to prevent circulatory overloading on the one hand, or shock on the other. In patients that have disease of the heart, blood vessels, lungs, or kidneys, the tolerance for deviation from a normal blood volume be-

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**Instructor, University of Louisville School of Medicine.
***Former Director of Louisville Regional Red Cross Blood Center; Clinical Professor of Medicine, University of Louisville School of Medicine.

comes less. It is important to remember that the hemoglobin and the hematocrit determinations at the time of the acute blood loss may give no indications of loss until hemodilution has taken place.

If the blood loss is less rapid, larger losses are well tolerated. Blood loss that might bring the hemoglobin down to 7 or 8 grams or lower may be well tolerated without transfusion if the total blood volume is maintained. The volume of the intravascular compartment may be able to be maintained by compensatory expansion with non-hemoglobin fluids such as albumin, plasma, other plasma expanders, or even electrolyte solutions. Butcher at Barnes Hospital has recently championed the use of Lactated Ringers Solution in rather large amounts to maintain the blood volume[3]. He has overcome the problem of the capillary leak of fluid containing small molecular weight ions by giving 2 to 3 times the amount lost in order to fill the extra cellular space. Blood transfusion is given only after the blood loss lowers the hemoglobin below a point that is well tolerated. Recently, there has been a justifiably great emphasis on avoidance of the single unit "cosmetic transfusion". However, a single unit may be indicated in situations where one unit is all that is necessary to elevate the volume or hemoglobin above a critical level.

A discussion of the clinical guides in the management of such patients is beyond the scope of this paper, but emphasis should be placed on a close follow-up of vital signs, change in the recumbent and sitting blood pressure, and urinary output. Blood volume measurements are helpful if variations from normal calculated values are kept in mind.

Whole Blood

In the majority of transfusions in which whole blood is indicated, there is concern only about adequate volume replacement and sufficient oxygen carrying capacity of the red cells. However, blood is a very complex fluid containing other cellular elements, proteins, and electrolytes that may deserve consideration in special situations. There are changes in the red cell survival, platelets, labile coagulation factors, and electrolyte composition as blood ages which are normally insignificant but may become important under certain specific circumstances.

The red cell survival of fresh blood is 90% of normal if given within 24 hours of collection with the survival decreasing to about 70% at the end of the 21 day dating period. The problem in acute blood loss is immediate replacement of the decreased volume and the length of survival of the red cells is of little importance. Whole banked blood up to the 21 day dating period is quite satisfactory for transfusion if the patient has normal bone marrow function. Here the difference between the 90% survival of fresh blood as compared to the 70% at 21 days is not significant. After the initial crisis is over, the normal marrow will increase its output to replace the transfused cells as they are slowly lost from the circulation.

For maximum use of the available blood supply, the oldest banked blood on inventory should be used to fill routine orders as they are received. Fresher blood should be specified only in situations where a definite indication exists since unnecessary requests place an unwarranted burden on the blood supplier. *Very fresh* blood (within a few hours of collection) should never be requested unless an attempt is being made to transfuse viable platelets or unless there is a known deficiency of one of the labile coagulation factors. Such requests have to be handled individually and special donors may have to be recruited and bled. Therefore there should be adequate laboratory confirmation of either thrombocytopenia or of a plasma factor deficiency before such requests are submitted.

Relatively fresh blood (within 5 to 10 days of collection, or as fresh as available on the shelf without special handling) may be justifiably requested for some patients with liver or kidney disease, or inadequate bone marrow function, for reasons which will be discussed. Leukocytes are rapidly destroyed by present blood collection techniques and white cells cannot be given beneficially at this time. Transfusion is therefore not indicated if the clinical problem is primarily one of leukopenia.

In rare instances, the administration of massive quantities of banked stored blood may lead to deficiencies of labile coagulation factors or platelets[4]. This rarely becomes a problem unless there is almost total replacement

of the normal blood volume. As a rule of thumb, for most patients, there is little difficulty until more than 10 or 12 units are given.

The sodium content of a unit of whole blood is about 50 meq. and is of little importance in the patient with normal cardiac or renal function, but may be significant if these functions are decreased. Hyperkalemia may be a problem in both liver and kidney disease and may be an indication for specifying *relatively fresh* blood since the potassium ion slowly leaks from the red cells during storage, increasing the concentration in the plasma from 4 to 5 meq. per liter in fresh blood to over 30 meq. per liter at 21 days. Citrate toxicity is rarely a problem since the normal liver readily metabolizes this molecule, but theoretically can produce cardiac problems or hypocalcemic tetany in infants or adults with severely compromised liver function or in situations where massive transfusions are given.

Transfusion to Improve Oxygen-Carrying Capacity

PATHOPHYSIOLOGY OF CHRONIC ANEMIA

While acute blood loss is the *single* major indication for whole blood transfusion, a wide variety of pathologic processes may lead to chronic anemia without major volume changes. Here the preferred treatment product is packed red blood cells if transfusion is required. Basically such anemias are either the result of decreased bone marrow production of red cells accelerated destruction (hemolysis), chronic blood loss, or some combination of these processes. As in any illness, proper management depends on accurate diagnosis and on an understanding of the pathophysiologic problems involved.

When a significant anemia is found, efforts should first be made to establish the etiology before any treatment is given unless the patient is suffering from symptoms of anoxemia at rest. There is no justification or rationale for the use of either emperic "shotgun" hematinic preparations or emperic blood transfusions in such situations. Treatment should be deferred until diagnostic studies have been completed unless the situation is such that the patient's life may depend upon transfusion first and diagnosis later. Even after diagnosis, transfusion should be avoided if there is any other form of therapy available.

In all chronic anemias, the ability of the bone marrow to respond to the stimulus of the anemia is of critical importance. The bone marrow is the most active organ in the body, and erythroctytes are produced by the marrow at a startling rate[5]. In the normal adult approximately 9 billion cells containing 6.25 grams of hemoglobin are produced daily. The rate of destruction is equal to the production and an equilibrium is established with a turnover of approximately 1% of the cells per day.

Under the stimulation of severe anemia the normal (or properly treated) marrow may be able to increase its production up to eigthfold and physiologically correct even severe anemias. If the anemia is on the basis of a deficiency (vitamin B12, folic acid, or iron) it should be treated by adequate amounts of the specific substance which is deficient. Steroids may be the agents of choice in the immune types of hemolytic anemia in which transfusion may lead to further hemolysis. Such problems as thyroid or other endocrine deficiency, infection, and malignant disease including leukemia and lymphoma, may be adequately managed by treating the underlying condition, at which time the blood count may spontaneously return to satisfactory levels.

There are, however, certain types of chronic anemia for which no specific therapy is available. If possible, patients with conditions such as aplastic anemia, uremia, or incurable malignancy should be allowed to stabilize at a level of hemoglobin which will allow satisfactory activity even though this may be well below accepted normal levels. Intermittent or chronic transfusion therapy only becomes necessary if such treatment means the difference between useful activity and disability. Again, the aim should be just to raise the hemoglobin to realtively asymptomatic levels. In these patients who do require regular transfusions, it may be advisable to specify *relatively fresh* blood or packed cells since the additional red cell survival of the fresher blood may allow more infrequent transfusions.

Important Characteristics of Packed Red Cells

In almost all chronic anemias (or acute anemias without loss of blood volume), packed red cells offer several distinct advantages over whole blood. Packed cells are prepared by

centrifugation or sedimentation and removal of approximately 80% of the plasma[6]. One unit of packed cells then contains the same number of red cells as in a pint of whole blood with about half the volume. This decreased volume provides more physiologic management in most chronic anemias, and may be of critical importance in patients who have a compromised circulatory system, since less volume adjustment is required[7].

In removing the plasma, most of the free sodium, potassium, and citrate are removed, avoiding the problems outlined in the discussion of the use of whole blood. Removal of the plasma also eliminates a good portion of the white cell population and a large quantity of the plasma proteins which are the leading causes of non-specific febrile or allergic transfusion reactions[8]. Finally, the use of packed cells rather than whole blood may double, triple, or quadruple the usefulness of a single pint of blood. If the plasma is removed as soon as the blood is drawn, it will still contain viable platelets and labile clotting factors. As discussed in the paper on blood fractions, plasma can also be processed to provide serum albumin, gamma globulin, and fibrinogen which are now in critically short supply. For such reasons, it is becoming increasingly desirable to use packed cells unless whole blood is specifically required. It is estimated that at least 30% of transfusions should be in the form of packed cells. Whenever possible, orders for packed cells should be submitted 24 hours prior to transfusion to allow the blood bank adequate time for procurement and preparation in a routine manner.

Technique of Administration

As is stressed in the paper on hazards of blood transfusion, a patient who receives a unit of mismatched or incompatible blood may have a severe transfusion reaction which can lead to shock, renal shutdown, and death. However, the signs of a transfusion reaction usually become apparent after infusion of a relatively small volume (25-100 ml.) of incompatible blood. For this reason, it is important that the patient be watched closely during the initial phase of blood administration, and that the first 50 mls. be given quite slowly over this period of time (less than 5 ml per minute). If any symptoms of a transfusion reaction develop, the transfusion can be immediately discontinued, usually before sufficient blood has been given to cause major morbidity. If no adverse symptoms have developed during the first 30 minutes, the transfusion rate can be accelerated. Patients who have a normal cardiovascular system can then receive a unit of blood safely within a period of about an hour or at a rate up to 10 to 20 ml. per minute.

Patients who have limited cardiac reserve or failure may require very slow administration, over a period of perhaps 3 to 4 hours, even if packed cells are used. It is a paradox that the most severely anemic patients require the most cautious administration since a delicate equilibrium can be upset and overload result with pulmonary edema[9]. If anemia is severe range of 2 to 3 grams), it may be judicious to perform a phlebotomy of the severely anemic blood from one arm while giving packed cells in the other arm, so that the hemoglobin can be effectively increased without any increase in blood volume[10].

Blood should not be warmed before administration unless cold antibodies are known to be present. In this situation, the temperature of the blood can be safely increased by passing the tubing through a water bath no higher than 37°C, or placing a heating pad on the recipient's arm above the site of infusion. Pressure transfusions may be required in severe blood loss, but air should not be pumped into the bottle because of the danger of air embolism. Medication should never be added directly to the bottle of blood. Anti-histamines which are frequently given prior to the administration of blood to prevent a hypersensitivity reaction, can usually be given quite satisfactorily at the first signs of difficulty. The use of anti-pyretics prophylactically is not good practice unless the patient is known to have febrile reactions on the basis of previous transfusion experience.

If a patient needs transfusion prior to elective surgery, time should be allowed prior to the procedure for physiologic adjustments to the change in volume. An arbitrary figure of 10 grams of hemoglobin is frequently required prior to surgery, but there are instances where patients who have adjusted to lower hemoglobin levels may be satisfactory surgical risks without transfusion. The anesthesiologist and surgeon should be flexible in considering cer-

tain of these special problems such as might occur in hereditary spherocytosis where a lifetime adjustment has taken place, and the hemoglobin will predictably increase rapidly after splenectomy.

Transfusion should be avoided while a patient is under anesthesia, if at all possible. Many of the helpful signs and symptoms of a reaction are masked and the patient may develop shock secondary to transfusion reaction without any means of recognizing the nature of the problem. The situation may then be aggravated by an increase in the rate of administration of the blood in an attempt to treat the shock resulting from the reaction.

Special Problems

Inability to obtain the proper type of blood or a compatible crossmatch for a patient that urgently needs transfusion is perhaps the most frustrating transfusion problem that is encountered by both the attending physician and the director of the transfusion service. In such situations, satisfactory solutions usually can be found if there is direct consultation between the physician, who is responsible for the patient, and the director, who is responsible for blood distribution and laboratory control.

BLOOD SHORTAGES

Regardless of the type of blood procurement program available to a hospital, shortages of certain blood types will inevitably be present from time to time. If this occurs at a time when a patient requires immediate transfusion, it is important to know what products or blood types can be substituted with relative safety until the proper type can be obtained. As noted above, serum albumin, plasma, or plasma expanders such as dextran and electrolyte solutions may be lifesaving by replacing blood volume even though the hemoglobin is not concomitantly increased. This may well allow time for procurement of the specific type with proper crossmatching, and *proper procedure should be followed in all but extreme emergencies.*

If the specific blood type cannot be obtained and red cells are required, low titer type O Negative blood can be used in an emergency situtation in a patient of any blood type. (O Positive blood is preferred if the recipient is known to be positive.) It should be stressed that use of O Negative blood is not without hazard since the plasma does contain antibodies againt A and B cells[11]. These antibodies can lead to the destruction of the patient's own cells of type A, B, or AB. If as many as 5 units of type O blood are substituted and further transfusion is required within 10 days, then transfusion with O blood should be continued, for the antibody level may be sufficient to cause major destruction of cells of the original type.

Certain of the rarer blood types may be in short supply when the total supply is quite adequate. For example, it is not uncommon to have a shortage of AB Negative blood if a large amount is required. In this situation, A Negative blood is the most satisfactory substitute because no anti-A antibodies are present and the anti-B antibodies are usually of low titer. If any type of blood is *critically* short, demand for blood of that type for non-emergent situations cannot be morally justified for it may deprive the individual that does have a critical need. Such problems require patience and understanding, particularly if elective surgery must be cancelled or hospitalization prolonged.

INCOMPATIBILITY IN THE CROSSMATCH

A compatible crossmatch requires that there be no antibodies in the recipient serum that will react with the donor cell (major crossmatch), and no antibodies in the donor serum that will react with the recipient cells (minor crossmatch). If an incompatibility exists, the transfusion must be delayed until compatible blood can be found by blindly crossmatching a sufficient number of units, or until the specific antibody is identified and blood that is negative for that group obtained. If multiple antibodies are present or if the patient has developed an auto-antibody that will react against all cells regardless of type, a compatible crossmatch may be impossible to obtain. A more detailed discussion of these problems, which can become very complex for medical and legal reasons, will be found in a subsequent paper. Before undertaking transfusion in a situation where incompatibility is known to exist, the physician must either have a very clear understanding of the problems

and dangers involved, or obtain the most expert advice that is available to him.

AUTOTRANSFUSION

One practical consideration for patients who have either a very rare blood type or antibodies that make crossmatching difficult is the use of the autotransfusion technique. If the hemoglobin levels are adequate, the prospective patient for elective surgery may be bled between 7 to 14 days before the procedure so that one to two units of his own blood will be available if needed at the time of surgery or in the immediate post-operative period. This procedure may well become increasingly popular, even for patients with no crossmatching problems, since a *completely* compatible unit of blood can only be obtained from the individual himself or an identical twin.

Summary

Blood transfusion is a lifesaving but potentially dangerous method of treatment. Its use should be avoided if any other method of patient management is available. When transfusions are necessary, the physician should understand the pathophysiologic considerations of the individual patient and tailor the therapy on this basis. Whole blood may be required in situations of acute blood loss, but packed cells are the preferred product when an anemia is present where loss of volume is not a significant problem. It is important for the physician and the nursing service to recognize the dangers inherent in transfusions and the clinical signs of a transfusion reaction. There should be free consultation between the physician and the laboratory service to enable best use of this product and to cooperatively solve any problems related to its use.

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Medical Hazards of Blood Transfusion

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WITH the increased availability of human blood and the simplification of techniques for its administration, transfusion therapy has been used with greater frequency to the benefit of innumerable patients. Inevitably, however, the increased use of blood has made proportionately greater the risk of observing unfavorable effects of transfusion. Broadly, these unfavorable effects are indicated with the name of "transfusion reactions". As defined by the Committee on Standards of the American Association of Blood Banks (1) transfusion reactions usually fall into four groups: 1) allergic, 2) febrile, 3) overloading, 4) hemolytic.

The *"allergic"* reactions include urticaria, facial edema, bronchial spasm, laryngeal edema. These phenomena are precipitated by an antigen-antibody reaction when the plasma infused contains an antigen and the recipient's the corresponding antibody or in the opposite situation, when the infused plasma contains an antibody and the recipient's the corresponding antigen. The occurrence of these complications, especially urticaria is approximately 2%. Severe allergic reactions are fortunately rare, only 1/10 of 1 percent and less likely to occur not only if donors are carefully screened but also if the recipient's allergic history has been evaluated and proper measures taken in case of positive record of allergic sensitivity.

In fact, evidence has been presented that most of the allergic transfusion reactions depend on exaggerated sensitivity of the recipient rather than on abnormalities of transfused blood. Because of the high frequency of allergic reactions, the introduction of antihistaminic compounds into every blood bottle before infusion has been practiced. Entering the bottle for addition of medications has now been condemned[1]. The indiscriminate use of antiallergic drugs is also inadvisable and institution of treatment should be reserved only for the patient who develops symptoms. In case of strong allergic history of a perspective recipient of blood, however, the oral or parenteral administration of an antihistaminic to the patient preceding the transfusion is an acceptable exception. In rare particular cases even the administration of corticosteroids may be indicated.

The *"febrile reactions"*, also very frequent, are provoked by introduction into the recipient of "pyrogens", of incompatible leukocytes or platelets, or by infectious agents carried by the infused blood. Pyrogens are most often polysaccharides of high molecular weight of bacterial origin[3]. These contaminants of glassware and of the chemical compounds used for anticoagulation are now rarely found in commercially available materials.

Leukocyte incompatibility is responsible for over 50% of all the febrile transfusion reactions[4]. Leuko-agglutinins, usually present in the recipient plasma, are incriminated for these unfavorable effects. The reaction is characterized by flushing, chills, fever and, rarely, hypotension, tachycardia, cyanosis and activation of fibrinolysin. The untoward effects are observed only when more than 1×10^9 white blood cells are administered. These effects are provoked by both viable leukocytes and by non-functional cells such as those present in blood preserved for many days. Avoidance of the reaction is usually obtained if 80% or more of the white blood cells are removed from the donor's blood by means of centrifugation and aspiration of the buffy coat.

Buffy coat-free blood should theoretically be used nearly every time blood is administered but this is presently impossible for practical considerations. The use of leukocyte poor blood is desirable or necessary if a patient consistently experiences severe febrile symptoms following transfusions, in candidates of numerous or massive transfusions, and in patients with hyper-immune diseases. Moderate febrile reactions may be mitigated or suppressed by prophylactic antipyretics or corticosteroids but not, apparently, by antihistaminics.

Febrile reactions due to the infusion of incompatible platelets are less well understood but are probably limited to patients who have been sensitized by previous multiple trans-

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fusions. Removal of buffy coat for preparation of leukocyte poor blood, is also effective in reducing the number of platelets.

The febrile reaction caused by infectious agents is still a potential danger risked every time blood is administered. Frequent source of blood contamination is the donor's skin at the site of venipuncture. Entering the bottle before administration of blood should always be considered a dangerous practice liable to produce infection. Most of the organisms contaminating blood are gram-negative coliform or pseudomonas. Some of these, the so-called pyschrophilic organisms, grow perferentially in the cold.

The introduction of bacterial contaminants in the recipient is often a severe and not infrequently a fatal complication. Its incidence is reduced by careful preparation of the donor's arm, by the use of blood older than 2 or 3 weeks[5] and by strict observance of Blood Bank rules concerning refrigeration and entering of the bottle. Blood should be refrigerated until the moment of use. Unused blood returned to the Blood Bank should not be reissued unless kept continuously at 1 to 10°C, and only if the container's closure had not been disturbed. If the administration of cold blood is contra-indicated, the tubing through which the blood is being infused, rather than the bottle, should be warmed. The supernatant plasma of each unit of blood should be inspected for abnormal color, clots and cloudiness preceding administration. The clinical syndrome of a reaction due to infusion of heavily contaminated blood is ordinarily dramatic: the patient experiences chills, fever, abdominal cramps, vomiting, bleeding tendency and shock. If these symptoms occur, the infusion should be discontinued at once, bottles and tubings sent to the Blood Bank for microscopic and cultrual studies. Should bacteria be found by immediate phase microscopic observation, or on stained preparations, or if septicemia is suspected on clinical basis, broad spectrum antibiotics are indicated before confirmation by bacterial culture. More blood or plasma may be indicated to treat shock.

Transmission of viral hepatitis by infused blood is theoretically considered a "blood transfusion reaction", even though the effects of the infection are delayed. Prevention of transmission of this infection is almost exclusively the task of blood collection centers through appropriate screening of donors.

"Overloading reactions" include mainly circulatory complications due to rapid changes in blood volume. Citrate and potassium toxicity as well as hemosiderosis may be briefly mentioned in this paragraph. While the most frequent reasons for administering blood are the need for improvement of the oxygen carrying capacity and the need for increasing the blood volume, a sudden change of the red blood cell or plasma mass is poorly tolerated by elderly, debilitated or cardiac patients.

In the elderly and in cardiac patients the rate of transfusion should not exceed 5 ml (100 drops) per minute and in the decompensated patient 3 ml (60 drops) per minute. For the prevention of circulatory overload, a part from the regulation of the rate of infusion, the use of "packed red blood cells" is indicated. when the main reason for transfusing is anemia. Circulatory overload may occur during or shortly after completion of the transfusion. Its symptoms and signs are dyspnea, cyanosis, cough, frothy or blood tinged sputum, moist pulmonary rales. Sudden death is not an infrequent consequence. If this syndrome develops, the transfusion should be immediately stopped and tourniquets applied at the extremities for 10-15 minutes. Should cyanosis and dyspnea continue, withdrawal of approximately the same quantity of blood which has been given may be beneficial.

Citrate toxicity may be observed in infants treated by exchange transfusions, in patients receiving massive amounts of blood or in hepatic patients receiving blood too rapidly. The toxic effects of citrate are almost exclusively confined to cardiac symptoms. Interference with blood clotting is not a significant consideration. Electrocardiographic changes include prolongation of the ST segment and possibly depression of P and T waves. These effects are not due solely to hypocalcemia but to an effect of the citrate per se. Regulation of the infusion rate to allow metabolism of citrate and the use of packed red blood cells especially in hepatic patients is, therefore, more effective than giving calcium preparations. In infants undergoing exchange transfusions or in cases where the very rapid administration of large quantities of blood is indicated 5-10 ml of calcium gluconate every 2-3

units of blood is an appropriate procedure.

The concentration of potassium in the plasma of preserved blood increases progressively during the period of storage as outlined in the papers on whole blood and packed cells. As for citrate toxicity, dangerous effects from potassium are most often observed in infants given exchange transfusions or in case of massive administration of whole blood stored for longer than 2 weeks. Electrocardigraphic changes characteristic of hypopotassemia may be observed.

Transfusion hemosiderosis is an almost unavoidable consequence of prolonged administration of blood in hematologic patients receiving an excess of 100 units of blood. The availability of powerful iron chelating agents, presently under development should provide an effective means for the prevention or correction of this complication.

A *"hemolytic reaction"* is usually an indication that incompatible blood has been administered to a recipient; namely, that the red blood cells of the infused blood are being destroyed by antibodies present in the recipient's plasma. The destruction of red blood cells may take place intravascularly or extravascularly (mainly in the liver and the spleen). Hemoglobinemia, however, develops with either mechanism and even when relatively small quantities of incompatible erythrocytes are infused, such as 10-20 ml[6], due to the rapidity of their destruction. The existence of an extravascular mechanism for removal of of incompatible red blood cells explains why antibodies which are not hemolytic in vitro may provoke a hemolytic reaction in vivo.

Antibodies injurious to incompatible red blood cells are spontaneously present in man only in the case of agglutinins against blood group substances ABO. In most of the other cases the antibodies have been stimulated in the recipient by earlier exogenous introduction of antigens, ordinarily by previous transfusions or pregnancies. The techniques of investigation of red blood cell antigens in blood to be transfused and the characterization of antibodies in the recipient's plasma is constantly improving; the necessity of selecting blood least liable to provoke "silent sensitizations" is felt more often. It is, therefore, expected that the danger of hemolytic reactions due to rare antibodies will become less in the future.

The great majority of potentially hemolytic antibodies are today easily recognizable by Blood Bank techniques. Thus the incompatibility reaction more often result from human error rather than technical difficulties. Mistaken identity is one of the most common causes of hemolytic reactions. Rigid control measures to assure that the patient receives blood crossmatched with sample of blood taken from him is the responsibility of the hospital and the individuals administering the tarnsfusion.

Immediate symptoms of a hemolytic reaction are frequently confined to a hot sensation in the arm where blood is infused. Severe chills, pain in the lumbar region, nausea, vomiting, fever, fecal and urinary incontinence and shock may follow. Bleeding tendency, hemoglobinemia and hematuria may be observed. Occasionally these symptoms and signs are not noticed or the unfavorable effects are delayed. One of the most frequent and severe delayed complications of an incompatible transfusion is the acute renal failure.

The effects of incompatible blood become apparent after the administration of only small volumes. In consideration of this and in view of the fact that serious consequences are minimized if the quantity of incompatible blood administered is small, it is advisable for a competent individual to observe the patient during the infusion of the first 25—50 ml of blood. In case of appearance of symptoms interruption of the transfusion is imperative. The unused blood, a sample of the patient's blood and urine specimens should be sent to the laboratory for appropriate studies. The care of the patient should include the administration of more blood, even unmatched O negative blood[1] if the reaction is due to ABO incompatibility and shock develops. Diuresis should be initiated soon after the reaction and continued until the danger of renal failure has passed. Should oliguira and uremia take place the use of osmotic diuretics or dialysis may be indicated to support the patient until recovery from the renal injury occurs.

(Continued on Page 894)

Typing and Crossmatching Procedures at the University of Kentucky Medical Center Hospital Blood Bank;

With Observations on the Incompatible Crossmatch

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ADVANCES in immunohematology and blood banking have proceeded at a record-breaking pace over the last twenty-five years. Consequently, administration of blood and blood products has become common and safe. Technological strides have elucidated a complexity of antigen-antibody systems which many blood banks are capable of identifying. As a result, much of the "trial and error" technique in obtaining compatible blood has been eliminated. However, the field is vitally alive as new blood factors are being constantly discovered at an alarming rate.

The purpose of the routine crossmatch is to detect antigen-antibody systems that may lead to an intravascular hemolytic episode. However, the routine crossmatch does not always reveal the presence of all antibodies. For example, in a given crossmatch, the patient's serum may contain an antibody for which there is no corresponding antigen on the donor's cell, or vice versa. An "ideal" crossmatch would involve approximately twenty tubes incubated at 37°, 25° and 5° C. in several different media. That is obviously impractical for routine use, and one depends on a less complex crossmatch procedure. Such a crossmatch should conform to the standards of the American Association of Blood Banks. The possibility of overlooking antibodies may be readily circumvented by preliminary antibody screening of patient's and donor's sera. Their identification alerts the blood bank personnel of their presence, not only as related to an imminent transfusion, but also as valuable information for future reference.

Antibodies Most Frequently Encountered

Table 1 demonstrates the variety of antibodies that are not only responsible for hemolytic transfusion reactions, but, for the sake of completeness, also those encountered in hemolytic disease of the newborn, and those responsible for decreased cell survival. Each system will be briefly described.

TABLE 1. ANTIBODIES MOST FREQUENTLY ENCOUNTERED*

Hemolytic Transfusion Reactions	Hemolytic Disease of The Newborn	Decreased Cell Survival
ABO	ABO	
Rh-hr (D,c,E)	Rh-hr (D,c)	
Kell (K)		
Duffy (Fy^a)		
Lewis (Le^a)	Kell (K)	Lewis
(Le^a+Le^b)		M
Kidd (Jk^a)	Duffy (Fy^a)	P
S	Kidd (Jk^a)	I

Less frequent antibodies found are: N, Cellano (k), Duffy (Fy^b), Lewis (Le^b) and s.

*(*Table used with kind permission of Ortho Pharmaceutical Company, Raritan, New Jersey.)*

ABO SYSTEM:

THE ABO System was discovered by Landsteiner in 1900. Despite its "antiquity" and our familiarity with it, it is unfortunately the commonest cause of severe hemolytic trans-

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fusion reactions. Because of the technical ease of typing in the laboratory, these reactions are usually caused by an administrative error. They may be due to carelessness in labeling, to technical error, or failure to check the patient's identity before giving the transfusion.

Rh-Hr SYSTEM:

Anti-D was discovered in 1939 by Levine and Stetson in a Rh negative woman who had a hemolytic transfusion reaction following transfusion with her husband's blood. Work by Levine and Weiner in the United States and Race and Taylor in England elucidated the complexity of the Rh system. This resulted in other antigen-antibody systems as C, D^u and other rarer, troublesome combinations.

The Rh-Hr system is the common cause of erythroblastosis fetalis, but may also lead to a hemolytic transfusion reaction. The antibodies D, c, E are usually incriminated; D and c are most commonly the cause of hemolytic disease of the newborn.

The *"percent or incidence of compatibility"* is defined as the number of donors per 100 that will crossmatch with a patient having a particular antibody; this term will be used throughout the remainder of the paper. For example, germane to the Rh-Hr system, the incidence of compatibility with anti-D is 16%, anti-c is 20%, and anti-E is 80%.

KELL SYSTEM:

The Kell system was discovered in 1946 by Coombs, Mourant and Race in a newborn infant whose cells were direct Coombs positive in a mother who was Rh positive.

This antibody can cause both hemolytic transfusion reactions and hemolytic disease of the newborn. The "percent of compatibility" with donor blood is approximately 92%.

DUFFY SYSTEM:

The Duffy (Fy^a and Fy^b) system was discovered in 1950 by Cutbush, Mollison and Parkin. They found anti-Fy^a in the serum of a hemophiliac who had received several transfusions. It may cause hemolytic transfusion reaction and hemolytic disease of the newborn. The "percent of compatibility" with donor blood is approximately 35%.

LEWIS SYSTEM:

Anti-$Lewis^a$ (Le^a) was first discovered in 1946 by Mourant. Later Anderson found anti-$Lewis^b$ (Le^b). These antibodies will cause hemolytic transfusion reactions, as well as decreased cell survival.

It is one of the most dreaded antibodies because it is difficult and tricky to detect and identify. These antibodies may either occur in the single form or in combination, as anti-Le^a+ anti-Le^b. The "incidence of compatibility" with anti-$Lewis^a$ is approximately 77%, anti-$Lewis^b$ 22% and the combination of the two about 6%.

KIDD SYSTEM:

The Kidd system was first described in 1951 by Allen, Diamond, et al., in the serum of a mother who had given birth to an infant with hemolytic disease. It, too, causes hemolytic transfusion reaction. The "incidence of compatibility" with donor blood is approximately 25%.

S SYSTEM:

The S system was first described in 1949 by Cutbush and Mollison in a patient who had received a series of transfusions and developed increasingly severe hemolytic reactions with hemoglobinuria.

This antibody also rarely occurs naturally. The "incidence of compatibility" with donors is approximately 45%.

MNP SYSTEM:

The MNP system was first described in 1927 by Landsteiner and Levine. Anti-M usually causes decreased cell survival, but there are also some reports describing its role in hemolytic transfusion reactions. Its "incidence of compatibility" with donors is approximately 22%. Anti-P may be naturally occurring or immune. It is usually active in causing decreased cell survival. Its "incidence of compatibility" is approximately 25%.

Other less commonly encountered antibodies are Anti-N, anti-Cellano, anti-$Duffy^b$, and anti-s̃.

Typing the Donor and Recipient

In the University of Kentucky Medical Center Blood Bank when a recipient's specimen is received for type and crossmatch, it must have been freshly drawn in a clean dry test tube and properly labeled with the recipient's full name, hospital number, and date. A specimen received without those requirements will not be processed. Our recipients and donors are grouped for ABO and typed for Rh factors with two different commercial antisera[1] by the slide method. Both direct and reverse ABO grouping is done, the latter being done with known A_1 and B cells which we prepare fresh each day. If desired known A_1 and B cells may be purchased from commercial sources. All Group O specimens are further typed with anti-A, B (Group O) serum to detect possible sub-groups of A. Rh typing is done by the slide method; the tube method is employed if any slide reactions are not clearcut. When Rh typing an albumin control is performed with each specimen to check for pseudoagglutination or autoagglutination. We type all of our recipients with anti-D and anti-c and the donor with poly-valent anti-CDE and anti-c.

The Rh (CDE) negative donors are tested for D^u by the indirect Coombs technic.

The chosen unit for crossmatch is type specific for ABO and Rh(D). If a recipient is c negative and a female within childbearing age we use c negative blood.

The Crossmatch

The crossmatch is devised to detect all antigen-antibody systems of clinical significance. The crossmatch must be controlled as to temperature, time of incubation, and suspension media in which the various systems react optimally. Thus, our crossmatch consists of a four tube major-minor procedure, which conforms to standards set by the American Association of Blood Banks. On the major side, saline as well as albumin tubes are employed. We use fresh serum from the patient against a 2-5% suspension of donor's cells in saline for the saline tube and a 2-5% suspension of the donor's cells in his own serum for the albumin tube. Two drops of 22% Bovine Albumin are placed in the albumin tube. A similar procedure is followed for the minor side of the crossmatch. The tubes are centrifuged immediately and observed for agglutination or hemolysis, or both. The four tubes are then incubated at 37° C. for fifteen minutes. Following incubation the tubes are recentrifuged and again observed for agglutination and hemolysis. Either hemolysis or agglutination signals incompatibility. The indirect Coombs test[2] is then performed in the saline tubes, the final results being observed both macroscopically and microscopically.

At the time of, or prior to crossmatch, an atypical antibody screening test[3] is performed on the patient's serum and incubated along with the crossmatch. The donor's serum is screened at the initial time of typing and processing.

Investigation of the Incompatible Crossmatch

What should one do if a crossmatch proves to be incompatible? First, one must recheck the specimen for obvious errors such as labeling, or an error in typing the ABO or Rh systems. If unrewarding, the next consideration is to investigate for the presence of an antibody, either in the serum of the patient or donor. Antibodies causing crossmatching problems or incompatibilities may be conveniently subdivided into those that are pseudoagglutinins, autoagglutinins and isoagglutinins.

Pseudoagglutinination is a non-specific agglutination due to the presence of elevated protein, primarily globulin, in the serum. It may be strongly suspected when observing the agglutinated cells microscopically and noting they are in rouleaux. Rouleaux are usually easily prevented or dissociated by diluting the serum with saline. Pseudoagglutination should be suspected in the presence of liver disease, myeloma, macroglobulinimia, sarcoidosis, etc.

Autoagglutinins are antibodies to antigens present in the antibody producer; that is, antibodies formed by the host tissue against itself. Some believe such antibodies may result from iso-or autostimulation. There are two types of autoagglutinins, the warm or "hyperimmune", and, the cold or simple form. The former may occur in hemolytic anemia, leukemia, lymphoma and other hematological diseases. Of these about 10-30% are specific and may be identified by the use of panel cells. The remaining 70-90% are nonspecific in that they will re-

[1] *Ortho Diagnostics and Dade Reagents*
[2] *Ortho-Diagnostic anti-Human sera*
[3] *Ortho-Diagnostic Selectogen screening cells and Identogen panel cells*

act with all human red cells as well as the patient's own cells. The latter form can be detected by crossmatching the patient's cells against his own serum. This particular type of antibody may present a real crossmatching problem. If blood is needed for elective surgery, it might be necessary to bleed the patient and store his own blood for potential reinfusion at the time of surgery.

The cold form of autoantibodies may be demonstrated in patients who are pregnant, have virus pneumonia, liver disease, pernicious anemia, or malignant disease of the reticutoendothelial system. They may be circumvented in most cases by doing the crossmatch at 37° C. Most are now believed to be specific anti-I. This antibody demonstrates a wide range of panagglutination because of the rare occurrance of an I negative individual. Crossmatching the patient against himself at a cold temperature may help to alert one to the correct solution. Absorption of the non-specific cold antibody at 5° C. is another means of dealing with the problem.

Isoagglutinins are specific antibodies that occur after antigenic stimulation from other individuals of the same species. These comprise the bulk of antigen-antibody reactions and include such antigen-antibody systems as Rh, Kell, and others previously mentioned (see table 1). These antibodies may be identified by the use of an antibody identification panel consisting of Group O cells of known genotype[4]. Simultaneously with the initial crossmatch, an antibody (Selectogen) screen is performed on the recipient's serum. If the (Selectogen) antibody screening is positive, and the crossmatch similarly incompatible, the next step is a panel cell study of the recipient's serum. This identifies the specific antibody in question. Blood to be considered for a crossmatch may be tested for the offending antigen using special typing serum; if that antigen is present, the unit is eliminated from further consideration. Several units may be tested until a compatible one is obtained for crossmatching.

The identification of a specific isoagglutinin is dependent on two main factors; they are, the temperature, and, media in which the reaction takes place.

First, nearly all antibodies have individual optimal *temperature* ranges, and such knowledge may be of great assistance when attempting to identify a specific isoagglutinin.

For example:

1. The ABO system reacts best at 5°C. and begins to diminish in reactivity as the temperature rises. There is little or no reaction at 37° C.
2. The Rh-Hr, Kell, Duffy, Kidd, and S systems all react best at 37° C. and become less reactive at lower temperatures.
3. The Lewis system may react best at any temperature between 5° and 37° C. It is thought that the colder reacting forms of anti-Lewis are possibly naturally occurring while the warmer reacting forms are immune antibodies. This antibody is one of the most easily missed in crossmatching.
4. Anti-M and anti-P are cold antobodies reacting best at 5° C. There may be little or no reaction above 25° C. Anti-M has been found not only to be naturally occurring, but also has been found following stimulation by blood transfusion or pregnancy. In such instances, an increase in titer as well as thermal amplitude may be observed.

Antibodies are also defined, and identified, according to the media in which they react optimally. First order antibodies are the *complete* or *bivalent forms* commonly known as *saline antibodies*. The second order of antibodies are the incomplete or *monovalent forms* which are known as *conglutinins, albumin* or *"blocking"* antibodies, which are detected in a high protein medium. The third order are cryptoagglutinoids reacting only with the use of *anti-human-globulin (Coombs) serum*. The same antibody may be detected in saline, albumin and Coombs phases. However, optimal reaction usually occurs in one media or the other. Therefore, this fact is considerd in testing for antibodies. Unfortunately, a given antibody does not always follow a strict pattern. Examples of antibodies related to optimal reacting media are as follows:

1. The ABO system reacts well in saline and albumin but may react weakly in the indirect Coombs phase. This system may or may not require complement, and, when complement is present complete hemolysis or hemolysis plus agglutination may be observed.Hemolysis in any antibody test has the same significance as agglutination and will often be ob-

[4]*These cells may be obtained commercially from such companies as Ortho Diagnostic (Selectogen and Identogen) or Pfizer Diagnostic (Combicell).*

served only in the presence of fresh serum containing adequate complement.

2. The Rh-Hr system reacts best in the albumin and the indirect Coombs phases. If in an early immune state, or of a high titer, reactions of less magnitude will also take place in saline. This is especially true when anti-C and anti-E accompany anti-D.

3. The Kell, Duffy, and S systems are strictly Coombs reacting antibodies. Coombs test reaction will take place in either saline or albumin media during the incubation period.

4. The Kidd system is also Coombs reacting but requires complement. Because of antibody instability, storage of such serum must be at —20° C. This preserves the serum complement as well as the antibody.

5. The Lewis system has variable modes of reaction. If complement is present, this antibody will hemolyze in saline and albumin and may or may not react in the indirect Coombs phase. The colder reacting forms are less likely to react in the Coombs phase, whereas the immune, warmer reacting forms may be detectable with the aid of Coombs serum. If hemolysis is observed in a crossmatch, the antibodies of the Lewis system should be strongly suspected.

6. Anti-M and anti-P are saline and albumin agglutinins but they may react weakly in the Coombs phase.

Summary

A carefully controlled technic is essential in a blood bank to insure safe and compatible blood transfusions. Accurate typing of a fresh, properly labeled specimen utilizing commercially high-titered anti-sera and known test cells is mandatory. A major-minor crossmatch, including saline, albumin and indirect Coombs phases will detect significant incompatibilities that might result in a transfusion reaction. By keeping the above mentioned principles and techniques in mind, a modern blood bank can provide relatively safe service to the patient.

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Blood Components - Their Preparation And Use

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Fort Knox, Ky.

WHOLE blood transfusions have been the mainstay of transfusion therapy since World War II. Yet, during World War II, the most commonly used blood component was plasma. Though valuable for volume expansion, plasma lacked the oxygen carrying capacity of the erythrocytes. Now, after two decades, the value of these as separate therapeutic agents is being realized. In fact, the majority of certified blood banks feel that a versatile program should contain not only the packed cell and plasma portions, but these should be further subdivided to provide highly potent and medically useful fractions for such problems as hemophilia, and agammaglobulinemia or for the individual needing tetanus antitoxin yet highly allergic to horse serum.

These fractions are not always part of the routine hospital blood bank operation but blood banks are the sources for the pooled plasma later used to produce these more specific portions. (Facilities such as set up at the Blood Transfusion Research Division, US Army Medical Research Laboratory, Fort Knox, Kentucky, for routine separation of the major fractions can be similarly implemented in any certified blood bank.)

Despite the general interest in blood fractionation, there is a lack of standardization in both preparation and storage. The plasma separation operation developed at Blood Transfusion Research Division was created to support military blood banks in Continental United States and overseas installations, based on available equipment and particular needs in terms of pints and specific blood components and this facility will be used to provide an example of the components prepared and how these components can be useful[1-5].

Other more complicated processing procedures are done by commercial firms and use of these specific products will be discussed briefly.

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Materials and Methods

The following blood components are prepared at the Blood Transfusion Research Division:

1. Fresh frozen plasma (single donor plasma (human)) fresh frozen.
2. Stored liquid plasma (single donor plasma (human)) or normal human plasma (pooled).
3. Packed red cells.
4. Platelet-rich plasma (human).
5. Platelet concentrate.
6. Leukocyte-poor whole blood.
7. Leukocyte-poor red cells.
8. Small units of whole blood for pediatric use.
9. Antihemophiliac globulin (Factor VIII or (AHG)-rich cryoprecipitates.

The Blood-Pack® units of Fenwal Laboratories were used, including the double, triple, and quadruple Blood Pack units. Plasmapheresis units were also employed. The Sorvall RC-3 general purpose automatic refrigerated centrifuge was used in the blood component preparations. Its special features of speed in terms of revolutions per minute-relative centrifugal force (RPM-RCF), refrigeration and acceptance of a 10-15 gram imbalance make possible component preparation (Fig. 1).



Fig. 1. Loading refrigerated centrifuge.

Packed Red Blood Cells (Human):

1. The key to technics of preparing blood components is time. Preparation follows, quite nicely, if we start with packed cells from fresh blood. The double unit Blood Pack is used to collect blood from healthy donors. After careful cleansing of the phlebotomy site, blood is collected into the larger acid-citrate-dextrose (ACD) bag with careful attention to thorough mixing of ACD and blood. Following the collection, both bags (one full, one empty) are immediately centrifuged at 4°C for 7 minutes at 5000 RPM, 6975 RCF.

2. Suspend the primary bag on the plasma expressor and open the temporary closure to permit flow of plasma into the satellite bag. Leave sufficient plasma on the red cells to provide a 60-70% hematocrit (Fig. 2).

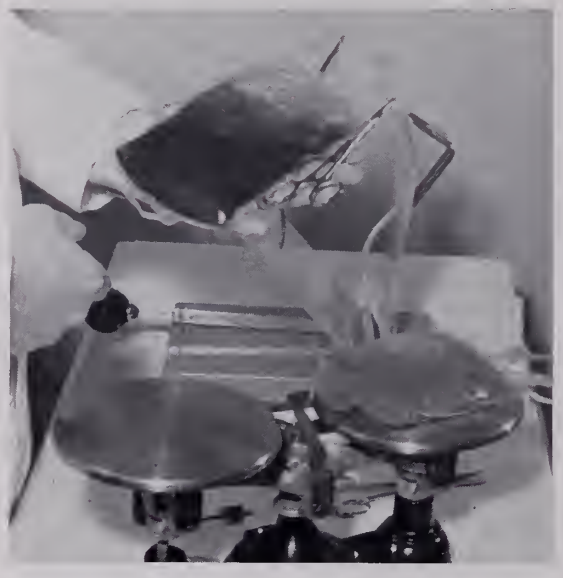


Fig. 2. Closed system preparation of fresh frozen plasma (300 ml-300 grams). Retention of sufficient plasma to assure hematocrit of 68% for 21-day usage.

3. Clamp off the tubing and seal in two places with a dielectric sealer or metal clamps. Separate the two bags by cutting between the seals and save segments of the integral donor tubing for pilot samples.

4. The label should carry the same information, blood group, Rh type, as for citrated whole blood (human). Store a proper temperature (4° C for red cells and −30° C for fresh frozen plasma in satellite bag).

Platelet rich plasma (human):

Again, the double unit Blood Packs are used in a similar manner to obtaining packed cells and plasma. However, the critical step here is that the bags are centrifuged at 4°C at 3100 RPM (2600 RCF) for 1 minute, 35 seconds. After centrifuge has attained speed of 2100 RPM (push brake at the end of the 1-minute 35-second timing). The platelet-rich plasma is obtained with the plasma expressor; the integral donor tubing dielectrically sealed and pilot samples collected as portions of the integral tubing on either side of the seals.

Should platelet concentrate be desired the platelet rich plasma is centrifuged immediately at 4°C for 7 minutes at 5000 RPM, 6975 RCF. The plasma is then expressed to a third integral bag and enough plasma left on the button of platelets to allow transfer of platelets in fluid form to the patient by simple rolling of bag with contents into recipient tubing at time of infusion.

Leukocyte-poor packed blood cells or whole blood:

Centrifugation was used to prepare this product from *fresh blood* only. While preparing the leukocyte-poor blood one should take advantage of the separation products by maintaining proper criteria of time and temperature during processing.

Preparation: Multiple bag unit with two satellite bags:

1. Centrifuge at 4°C for 1 minute, 35 seconds (push brake pedal) after attainment of 3100 RPM (2600 RCF).

2. Transfer the platelet and leukocyte rich plasma into one satellite bag.

3. Clamp the connecting tubing with a temporary clamp.

4. Recentrifuge at 4°C to pack all cellular elements.

5. Open the temporary clamp, remove the supernatant cell-free plasma.

If leukocyte-poor whole blood is desired, this plasma is returned to the primary bag. If leukocyte-poor packed cells are desired, this plasma and the plasma in the primary bag are transferred to the second satellite bag.

Plasmapheresis

The separation of plasma from whole blood by refrigerated centrifugation, and immediate return of the red cells to the donor is termed plasmapheresis. A double plasmapheresis set allows the withdrawal of two units of plasma and return of the red cells. The side arm

adapter above the needle makes vein patency possible and it is maintained by slow saline drip adjusted to avoid hypervolemic diuresis. For routine donation with the equipment presently available, it is best to limit donors to a maximum of 1000 ml of plasma withdrawn per week[8,10]. Following the serum protein level is essential before accepting the donor for repeated plasmapheresis and the determination should be made again after each cumulative donation of 1000 ml of plasma.

Curtailment of plasmapheresis is indicated when the total protein falls below 6.0 gm per cent in a representative sample of the donor's serum. The total protein may not reflect the amount of depletion of gamma globulin and it is known that once depletion takes place, recovery of gamma globulin may be prolonged[3]. For this reason, the electrophoretic pattern of the donor's serum proteins should be examined if total protein values are borderline[6,8].

The technic of plasmapheresis involves autotransfusion. Blood bank supervisors can appreciate necessary controls when multiple autotransfusions are carried out each day in one facility. The recommendation by Dr. Allan Kliman that group specific donors (A, B, AB or O) be restricted to each day's plasmapheresis operation is clearly indicated to prevent blood group incompatibility in the event of clerical or technical mix-up.

AHG-rich cryoprecipitates (Factor VIII component):

The preparation procedure used has been the method of Dr. Judith G. Pool[9] (Figs. 3 and 4). This relatively simple method of rapidly freezing, then cold thawing and separating the plasma for the remaining AHG rich cryoprecipitate appears to be a practical technique for preparing an effective antihemophilic factor concentrate.



Fig. 3. Thawed frozen plasma with AHG-rich cryoprecipitate.



Fig. 4. AHG-rich cryoprecipitate.

Discussion

Diagram 1 is used to illustrate some of the components and their usefulness.

The first step of separation provides plasma as single donor, pooled or as dried products useful as a basic volume expander. Because this material has a relatively low level of antibody, it can be life saving in severe blood loss, and time saving by not requiring crossmatching. Should these products be planned for

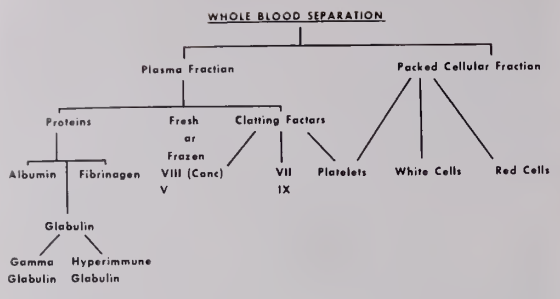


Diagram 1

chronic patient support rather than emergency use, single units from known donors would be preferred to reduce the risk of hepatitis.

Freshly drawn blood can provide all known clotting factors in the plasma, including platelets and, thereby, is considered the universal emergency therapy for bleeding dyscrasias. The new cryoprecipitate method of concentrating the antihemophiliac factor (Factor VIII) may supply a more potent and specific component and reduce the risk of developing antibodies to this factor. This method is new and has not been fully evaluated at this time.

In the protein separation, basic fractions consist of albumin, globulin or fibrinogen. The albumin has value as a plasma expander, and in burns, nephrotic syndrome, pancreatitis, cirrhosis, and hypoproteinemia and when its nutritional value is needed. Fibrinogen is necessary in specific deficiencies of this protein whether congenital or acquired but also carries the risk of hepatitis transmission. The globulin fraction can be used as prophylaxis for many infectious diseases, including hepatitis, and as specific replacement therapy in globulin deficient states. Additional subfractions can be obtained from plasma by commercial firms and include plasmin (fibrinolysin), ceruloplasmin, plasma cholinesterase, siderophilin, and highly specific immunoglobulins protecting against measles, mumps, pertussis, or tetanus.

The critical demand for gamma globulin and other blood fractions available only from human plasma have emphasized the need for an efficient plasma salvage program. The recognition of the lability of various portions has been the stimulus for programs designed to procure fresh plasma either by the immediate separation method as described, or through

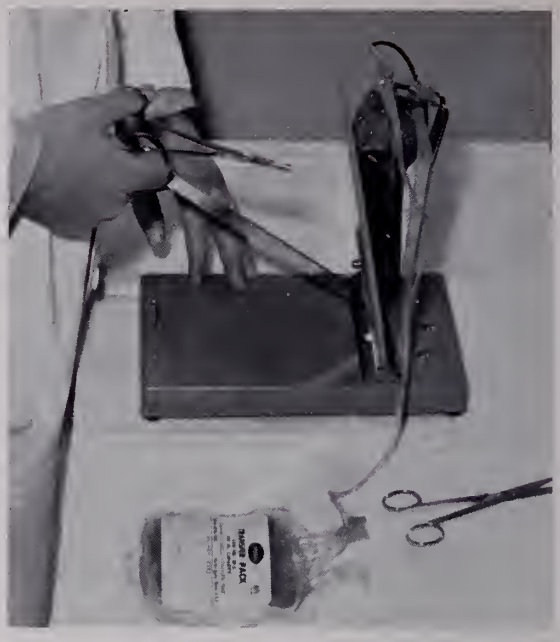


Fig. 5. Expressing plasma. Plasma salvage from outdated blood using attached transfer pack.

plasmapheresis. Though the demand for plasma is a sufficient reason to use packed red blood cells whenever possible, the packed cells frequently have distinct advantages when transfusions are primarily concerned with adding the oxygen transport function of red blood cells and not necessarily the volume function of whole blood as discussed in the preceding paper.

The separation process also does permit adjusting the concentration of the various components, for example, providing platelet-rich plasma or packed cells, or leukocyte-poor whole blood or red blood cells that may be therapeutically more useful in certain specific conditions and possibly reducing the risk of some of the adverse reactions of whole blood transfusion.

Hemophilia and fresh plasma therapy:

Fresh frozen plasma providing a means of furnishing an increase in the patient's circulating plasma AHF is essential for the hemophiliac with soft tissue and joint bleeding, not readily controlled by local measures. Where anemia and anoxia is not critical, treatment with fresh plasma is specific. A level of at least 5-15% should be maintained. This level can be reached by initial doses of fresh frozen plasma of 7 ml per pound of body weight. Subsequent doses of 3.5 to 5 ml, given at intervals of 4 to 12 hours for the first 48 hours,

will establish control.

Concentrations between 10-35% must be attempted where surgery or dental procedures are contemplated, or when traumatic injuries occur. The cryoprecipite AHF concentrate is under evaluation, and may be very useful in avoiding excessive volume infusion in these circumstances. Achievement of effective therapy can be monitored by the laboratory with the partial thromboplastin test[3].

Platelet transfusions are clinically useful and the criteria of effectiveness are usually platelet counts and cessation of external bleeding. In the last analysis, however, judgment of the value of platelet transfusions is largely based on clinical experience[10]. *In vitro* measurement of platelet functions does not serve as a useful index of clinical effectiveness. For example, Cronkite states that in general, bleeding appears at higher platelet levels when thrombocytopenia develops rapidly than when the process is chronic. Such thrombocytopenic bleeding may be controlled by the transfusion of viable platelets but quantitative evaluation of effectiveness is very difficult. Measurement of the life span of transfused platelets may be linear or exponential but the ideal method for performing such studies has not been described.

Freireich finds that hemorrhage resulting from thrombocytopenia in patients with acute leukemia and aplastic anemia can be controlled by platelet transfusions. Severe gross hemorrhage was rarely observed when platelet counts were higher than 20,000 per cu mm. When very large doses of platelets are required in a small volume then platelet concentrates (PC), prepared by centrifuging platelet-rich plasma and removing most of the plasma, are used. Platelet concentrates are 80 to 90% as effective as platelet-rich plasma in elevating the platelet count if prepared from plasma with a pH of 6.8 or less, achieved by the addition of citric acid[11].

Summary

Blood donation as a source of blood components has become increasingly useful due to two innovations of technic.

The first is the availability of plastics with a closed system of collection and separation eliminating the chief source of bacterial contamination.

Another major achievement stressed in the article is the use of a refrigerated centrifuge with high speed (RPM-RCF) capability for rapid and accurate acquisition of the various components and return of red cells to donor.

The use of components in various clinical states was discussed, particularly the use of packed red blood cells in normo- or hypervolemic states when oxygen carrying capacity is needed; the use of specific clotting factor therapy as well as hte use of platelets, albumin, and globulin with its subfractions.

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Medical-Legal Aspects of Blood Banking*

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WHILE transfusion of blood products has become one of our most valuable methods of treatment, the use of homologous blood products carries certain inherent dangers that have been repeatedly stressed in the preceeding papers. There has been particular recent interest in the dangers associated with the over use and abuse of blood transfusions, as well as the laboratory or administration errors which might cause major illness or death as the result of the transfusion itself.

Newspapers and magazines, such as *Time, Life,* and *Readers Digest,* have recently featured articles on these problems and have alerted the public to the potential dangers of transfusion. In many areas there have been an increasing number of litigation procedures with large judgements in favor of the patient if malpractice or negligence is proved.

Because of the number of people involved in the decision to use blood, its procurement, processing and administration, litigation can become very involved if it occurs. It is therefore important that blood not be given unless a definite indication exists, and, that individuals involved in its administration not only have adequate experience and training, but also understand and take seriously their area of responsibility.

The Medical-Legal aspect of Blood Banking may be divided into the various phases of a transfusion to point up the areas of responsibility of the many people involved in a transfusion. The obligation begins when the request for a transfusion is initiated by the physician and is over only when the transfusion has been received by the patient and he has exhibited no deliterious effects. This may require several weeks or months for final appraisal. Although the physician writing the request has nothing to do with the taking or processing of the donor blood, he shares in the responsibility if injury occurs. Because of the inherent difficulties which vary from human technical error to the unknown quantity, ie: hepatitis, blood factors not now known, sensitizing and immune factors not detectable, it is imperative that the disease being treated is severe enough to warrant subjecting the patient to the risks involved. A physician requesting blood for a patient in whom a reaction occurred has been held partially responsible because the transfusion was considered unnecessary[1].

The obligation of the physician requesting blood for transfusion continues during and after the giving of the blood. He is responsible for directing the personnel in the administering of the blood by giving accurate and implicit instructions ie: choosing the site to infuse the blood, the rate of administration and special conditions which may require close observation. He should therefore alert the nursing personnel as to possible allergic status of the patient, vascular or heart condition or the possibility of blood dyscrasia which might produce a severe hemolytic reaction ie: autoimmune hemolytic anemia or conditions in which leukoagglutinins may be present— to list but a few. The Anesthesiologists who administer much blood to patients during surgical operations, carry a big responsibility for early detection of a transfusion reaction while the patient is anesthesized as well as responsibility of proper patient identification.

Next in the chain of responsibility is the nurse or secretary who submits the request for the attending physician. It is necessary that the correct name, hospital number and room be transmitted to the Blood Bank. "It is stated that the methods in Blood Banking are now almost fool proof and that most errors are due to improper identification of the recipient of donor blood[1]. With this level of responsibility it is important that no short cuts be attempted.

The laboratory holds varied responsibility which extends from the donor to the recipient.

Acknowledgement—Appreciation is due to Mr. Roy Kirchoff, Newport, Ky., for his assistance in the legal aspects of this paper.

The taking of Blood Donors carries with it the responsibility, so far as possible to tell, that no harm be produced in a person donating blood, and, that they not be affected with a disease transmissable to a recipient of their blood. With reasonable certainty the first criteria can be met with an adequate history, hemoglobin, temperature, and blood pressure determinations and use of proper methods in taking of the blood. However the latter problem of ruling out transmissable disease is more difficult ie: detection of malaria in persons exposed in Viet Nam, viral hepatitis which is impossible to detect by laboratory methods and other unknown quantities. The responsibility to a recipient in the prevention of viral hepatitis is in dispute in many areas and involves the interpretation of implied warranty of biologic products. The extent of liability of the Blood Bank in transmission of undetectable diseases in the donor is in dispute and will depend upon individual court action.

The responsibility of choosing the correct technical procedures and selecting proper testing materials rests with the Director of the Laboratory. It has been shown that methods used must follow the standard procedure of the manufacturers[3]. During this phase of typing and crossmatching, the responsibility rests, for the most part, in the hands of the technician. While the hospital in the past enjoyed immunity from suits due to negligence of personnel, it no longer retains this position, and it is expected that suits against hospitals will increase.

Identity of the recipient and donor blood is one of the most critical points of the transfusion and, in the few cases of missmatches, represents the most recurrent site of error. After the blood is released by the laboratory as compatible, the persons administering the blood assume the responsibility of reviewing the record of the recipient, as to his type and to administer the compatible blood to the correct person.

A "reaction" of an allergic or hemolytic type may take place after receiving a small quantity of blood or may require several hundred cc's. The responsibility of the nursing service to detect a reaction as early as possible is as great as that shared by the other participants in the chain of transfusion. It is imperative that the unused portion of blood and appropriate blood and urine samples be sent to the laboratory for tests to determine the type of reaction. When the reaction is one of allergy there is no test, other than history, to predict the possibility; however, the hemolytic reaction due to "transfusion of the wrong type blood to a patient will be held to constitute negligence, or give rise to an inference of negligence[2]."

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3. Personal Communication.

Be Sure to Participate

KMA's Diabetes Detection and Education Week

November 13 thru 19

SPECIAL ARTICLES

Talking It Over: Medicine and Religion

JOSEPH H. SAUNDERS, M.D.*

Lexington, Ky.

GRANGER WESTBERG, in his book, *Minister and Doctor Meet,* tells of two experiences which occurred early in his parish ministery. One of his parishioners became ill and was hospitalized, and Doctor Westberg felt that he should call her physicians, which he proceeded to do. He relates the conversation went something like this: "Doctor Smith? One of my parishioners, Mrs. Johnson, is a patient and before I go to the hospital to call on her I wondered if there is anything you think I might be able to do that would be of help." Then followed a long silence at the other end of the line. When Doctor Smith had caught his breath he said, "Well, ah, I don't know anything about your business, Reverend; I make it a point to keep off the subject of religion. I can't tell you how to run your affairs." This ended the conversation on this patient.

On the second occasion when a parishioner became ill Doctor Westberg recalled that he summoned his courage and made a personal call to the physician's office. Unable to understand the purpose of his call the receptionist listed him as a new patient. The doctor gave him a warm welcome but when he found out the purpose of the mission, he said, "Oh, I don't think of anything in particular that you can do for Mrs. Blank, just pray for her. Everybody can stand a little prayer now and then, don't you think?" Doctor Westberg could see that the interview was over and he sensed that the common ground where the two professions stood some twenty years ago badly needed cultivation before the two disciplines, medicine and religion, would be able to recognize how they could help each other and through this mutual help aid the patient.

At that time it was commonly agreed as it has been for several hundred years that a physician was primarily a scientist who worked with the body, while the clergyman was a type of philosopher who cared for the soul. A very good job had been done of dividing man into these two compartments. It occurred to Doctor Westberg that it was not right that minister and physician, who spend so much time in hospitals dealing with the same people, should be miles away in their thinking about patient care at a professional level. Also, at that time there was very little recognition of the possibility of this inter-disciplinary communication on a professional level. Theology went its way and medicine its way.

One of the physicians who early recognized the need for communication between physician and minister was Richard Cabot, M.D., of the Harvard Medical School and author of *Cabot's Differential Diagnosis.* Doctor Cabot and the Reverend Russell L. Dicks collaborated in writing a book on the art of ministering to the sick. This was one of the earliest works, according to Doctor Westberg, that pointed out the need for a change in the hospital conversation by a minister from the stereotyped pastoral call of prayer and scripture reading to a conversation that could be truly pastoral and healing in nature.

One of the first things that Reverend Westberg felt that he should do in clarifying his own part in this program of ministering to the sick was to study his own role as to what he actually was to do and should do. I dare say that most doctors if they were asked what went on when a member of the clergy called on one of their patients, there would be almost a complete lack of knowledge in this field except if the clergy was making a call on the family of one recently deceased or if a priest were administering the last rites. In recent years schools of theology in all major faiths have made a real endeavor for their seminarians to understand this business of being sick and its relationship to their parishioners. Still there has been no communication on a society level between ministers and the clergy except in a relatively few cases. This more or less pioneer work was started in 1961 and has had in some areas of the country a very fabulous growth. In the state of Pennsylvania, in Colorado, in North Carolina even as far back as 1965 the state societies had a bulletin published by the committee on medicine and religion. Their component county societies had developed their programs to this level which required a separate communication.

At times when we have talked to various County Society chairmen about the role of this program of medicine and religion in their component societies, we have been told by the representative that their county program chairman or perhaps the President of the County Society had stated that they got along quite well with the ministers and that they had no arguments with them and there was nothing to be

* *Doctor Saunders is Chairman of the KMA Committee on Medicine and Religion.*

developed in this connection. This is true in many areas about the program of medicine and religion.

During the 1965 KMA meeting at the exhibit of the Committee of Medicine and Religion, interviews were conducted over a period of about three days with many physicians, ancillary personnel and several lay individuals. The replies we got to various questions were in some cases startling and all of them were interesting and thought provoking. The view expressed almost universally by the physicians was whereas not all patients who came into the hospital were in need of counseling or talking it out with the clergymen, many of the patients did need this help and doctors should recognize that in the care of the sick whether they be in the hospital, at home, or in the office, there is a spiritual side in the patient's makeup which the doctor is not trained to minister. It was in this area the physicians interviewed felt that the clergy could be of great help and assistance.

Many of the doctors stated that situations arose in which the minister was not only a great supporter to the patient but also to the family and this in turn relieved the tension and pressure which was sometimes put upon the physician. None of the physicians interviewed felt that calling a clergyman in consultation was a demonstration of weakness on his part nor that things were getting out of hand and he could not control them but it did show that his philosophy of life and his philosophy of the practice of medicine was not confined to science alone but to the spiritual side of man's existence. It did not mean that the physician expected a miracle to come about through a clergyman's call.

We all recognize that modern man is prone through his training or his environment to call upon God either in supplication in his hour of need or in anger and we also know throughout the world that man turns to his God by whatever name He is called for help. Several physicians were specifically asked if they believe the Rabbi or Minister could be of help in the care of some of the patients. When the answer was yes, another question was put to them. Did you develop this philosophy of belief in any course that you had in medical school or any instruction that you received in school or in your post-graduate training? The answer was, emphatically no.

Some of the fields that are open for "talking it out" with clergymen are the care of the chronic alcoholic, the chronically ill patient, the patient with a malignancy, the family of a child who is born with a physical or mental defect, the unwed mother and many of the others that have existed for years. However, now comes the time of the kidney transplant of the artificial organs to prolong life, along with what are also called extraordinary means. We all are familiar with the case or with cases of patients who because of a chronic terminal illness are vegetating through their last days on earth. Without hope of a cure should these be maintained by fluids, the artificial kidney, transfusions and other methods that are at our disposal? Or should we recognize that there comes to all creatures a termination of his life and that he should be allowed to die without these extraordinary means?

It is certainly not within the realm of this committee to make decisions as to whether these means should be employed, but there are questionable ethics here especially when the prolongation of life by these means is a financial burden upon the family to say nothing of the long and severe emotional strain. Of course in these latter days of Medicare, I don't know whether anyone is going to be too upset about the amount of money that is poured into ventures of this type, certainly not at the higher levels. Here again we cannot get into this discussion. Perhaps each of us can recall having heard a patient say after they have been brought back from what appeared to be a terminal illness, "Now I have to die all over again".

During the interviews, one with a senior medical student at the University of Louisville, the interview revealed the interesting fact that he had developed a philosophy of the inter-relationship of medicine and religion during his junior and senior years while working and seeing patients at the Louisville General Hospital. He was impressed by the importance of the spiritual side of patients and the recognition by the doctor that the spiritual side needed treating too. This young man was asked if this philosophy was one that he had developed from the medical curriculum and his answer was, "No, this was the result of my own experience plus my religious faith."

A physiotherapist related how much her charges, paraplegics and hemiplegics responded to the professional calls of the Chaplain. Many of these paralized individuals were young adults and needed that type of counseling and help that only a clergyman can give. A very intelligent business woman in Louisville demonstrated interest in our exhibit and consented to be interviewed and stated her firm belief that if a doctor did not have a deep religious faith that there was something lacking in his philosophical background and this would, in her opinion, limit his ability to care for his patient, that he was a completely one-sided individual.

Since the last year the State Committee on Medicine and Religion has been enlarged. Each trustee district has a chairman of Medicine and Religion and these chairmen are in turn responsible for the appointment of a County Society chairman or in those areas where several counties meet as one unit, an area chairman. Material from the office of Medicine and Religion of the AMA has been sent to each of these district chairmen and each trustee district chairman has been called by a member of the State Committee offering him his help in the formation of plans for the component societies.



EDITORIALS



Diabetes Week Approaches

ALTHOUGH we have known since the the time of the Declaration of Independence that sugar in the blood and urine are characteristic of diabetes, an unusually large number of people suffering from this disease fail to be treated, since they have not been exposed to testing. We approach, in this third week of November, the KMA sponsored sixteenth annual Diabetes Detection and Education Drive. Since it was first started, we have found, in Kentucky, 2,634 new diabetics, a really sizable number of people. Last year 252 new diabetics were reported, despite the fact that a smaller number than usual were examined. It is apparent that better than one in four hundred of the people tested on the Diabetes Detection Drive have diabetes, previously unknown and unreported. We have the opportunity, again, to render a real service in this diabetes detection program. We should make every effort to test a far greater number than we have in previous years, for in finding the unknown diabetic, we have the chance to prolong useful lives of many of our citizens. It is realized that not every positive urine test represents a diabetic, although, between 20 and 25% of those giving a positive test have been verified as new diabetics.

Verification of diabetes requires blood sugar testing. A number of methods are available for this in every community, from the simple dipstick test through the more elaborate laboratory procedures, some of which can be done through the State Health Department, when other methods are not readily available to the physician. It should be emphasized that if only a single blood sugar is taken, it should ideally be taken two hours after a normal carbohydrate meal. Reliance on fasting blood sugars for the diagnosis of diabetes will miss large numbers of patients. The more elaborate glucose tolerance tests are fine, but very few diabetics will be missed if, following the screening positive urine test or, in fact, without such a urine test, a random blood sugar is taken two hours after a meal. The urinalysis, itself, would have more meaning if the urine specimen was collected several hours after a meal rather than immediately after a meal and especially rather than a morning specimen.

All of us have an opportunity and a responsibility in this drive November 13-20 to perform a real public service finding the unknown diabetic patients.

Irving F. Kanner, M.D.

Reflections On Medicare

THE recent beginning of the Federal Medicare program commanded such attention in the public press that it temporarily displaced the Viet Nam War and the country's racial problems from the head lines and front pages. The lead articles of many popular national publications were devoted to the subject. Physicians were inundated with official and non-official explanations as to how the program was to work. The Federal Government carried out an intensive educational campaign by mail, radio, and television for the potential recipients of the Medicare benefits.

It had been predicated by some that there would be a rush on the hospitals by the states' elderly and some patients were apprehensive about the possibility of being unable to get into a hospital when needed. However, this expected rush failed to materialize and as Commissioner of Health, Russell Teague, M.D., stated, this can be interpreted as evidence that the people eligible for Medicare were getting adequate medical treatment before passage of

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Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP. Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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NOVAHISTINE® LP

For relief of nasal congestion.

arrest diarrhea



LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..... 0.025 mg.

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

Everyone says she's a barrel of fun



But what does she think?



Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

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DEXTRO-AMPHETAMINE SULFATE (15 mg.) WITH MEPROBAMATE (300 mg.) SUSTAINED RELEASE CAPSULES

to help establish a new dietary pattern

Contraindications: Dextro-omphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insamnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are cammon and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, ogranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosoge. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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the bill. However, it should be borne in mind that many hospitals were operating close to capacity. As the general public becomes more aware of the details of the program there may be an increasing pressure for hospital beds which will be gradual rather than the immediate pressure which was predicted.

The general public is still very much in the educational stage in so far as the Medicare program is concerned in spite of the well written and illustrated Medicare pamphlet which was distributed to all potential recipients of benefits. It has been apparent that some patients failed to read the pamphlet, others had misplaced it or failed to remember receiving it, others had glanced at it but had difficulty understanding the details of the potential benefits to be received. The particular points that demonstrated the lack of understanding concerned the fifty dollar deductible item of Part B and the fact that the cost of prescription medications was not provided for. With a good many patients that had the Blue Cross-Blue Shield sixty five and over policy in addition to Medicare there was confusion and lack of understanding as to what benefits each provided.

Many patients have turned to their personal physician and will continue to do so to instruct and to advise them as to what their benefits are. Most physicians are very busy people but they will have to take the time to become informed concerning the benefits available under the different plans and they will have to take the time to teach the patient about these matters. Good public relations for the profession frequently boils down to the relationship that exists between an individual patient and his physician and patients are not apt to forget the help and advice they receive in these situations. The medical profession speaking as a group often admonishes the public to turn to the profession in all health matters. When the individual patient does this the physician must take the time to provide an informed answer or that patient will turn to some one or some agency outside of the medical profession.

There has been considerable discussion concerning the two payment methods for Medicare services. The pros and cons of both methods are pointed out in the booklet "Medicare and the Physician" provided to all physicians by the American Medical Association. In general both organized medical groups and individual physicians have thought it best to use "direct billing" rather than "assignment" unless there be unusual circumstances involved. Most physicians offices now days are already heavily burdened with paper work and it doesn't seem unreasonable to ask the patient to carry out his own paper work in the collection of his benefits.

The present government reimbursement formula has provided a problem to some hospitals. The government payments apply only to the actual cost of caring for Medicare patients plus two per cent. It has been argued that the two per cent allowance does not sufficiently cover depreciation of capital assets.

The Social Security Administration reported that the latest estimate of the cost of the Medicare program is two hundred million a month for hospital benefits (Part A) and eighty million a month for medical insurance benefits (Part B). Considering all forms of medical and hospital service under federal programs that now exist, it is now estimated that nearly fifty-five million persons are potentially eligible. The annual cost of this service is about sixteen billion dollars.

There is almost certain to be pressures to expand medicare in the future. There will be pressure to expand the benefits such as providing the cost of prescription drugs for home use. There is apt to be pressure to lower the present age limits. Federal programs tend to grow and expand as the history of Social Security demonstrates. In 1935, government was paying for about eighteen per cent of health costs, in 1960, this had increased to twenty-four per cent and for the current fiscal year it is estimated that government will be paying thirty-two per cent of all health costs in the country.

Physicians of necessity will need to strive to keep fully informed, to observe new developments and to remain in a position to advise and direct in order that a social environment will prevail which will permit them to provide excellent health services to their patients.

WALTER S. COE, M. D.

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

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Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

RAUTRAX®-N

Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

ORGANIZATION SECTION

KMA Diabetes Detection Drive Scheduled for Nov. 13-19

The sixteenth annual Kentucky Medical Association Diabetes Detection and Education Week will be held during the week of November 13-19 according to Irving F. Kanner, M.D. Lexington, Chairman of the KMA Diabetes Committee.

The goal of this public service program, sponsored by KMA in cooperation with the American Diabetes Association, is finding and treating unknown victims of diabetes.

Doctor Kanner urged all KMA members to participate in this year's drive by checking urine samples free during the week of November 13-19 and submitting reports on number of tests made, number of positives discovered, and the number of new diabetics confirmed to the county diabetes chairmen.

Kentucky physicians have reported nearly 810,000 free tests administered during the past fifteen years that KMA has sponsored the drive. During this same period of time, over 2,600 new diabetics have been found.

Doctor Kanner stated that with the cooperation of the KMA membership participating in the program and the forwarding of results by the county chairmen to the KMA Headquarters Office, 1966 can be the best year to date for diabetes detection in Kentucky.

20th AMA Clinical Session Set For November 27-30

Variety will keynote the 20th Clinical Convention of the American Medical Association in Las Vegas, Nev., on November 27-30, according to an announcement from Charles L. Hudson, M.D., AMA president.

Closed circuit color television and medical motion picture programs, postgraduate courses and scientific sessions on 18 major topics headline the program. All scientific sessions and exhibits will be in the Las Vegas Convention Center.

Representing Kentucky at the AMA House of Delegates Meeting in the Dunes Hotel and Caesar's Palace will be KMA's delegates to the AMA—J. Thomas Giannini, M.D., Louisville; John C. Quertermous, M.D., Murray; and Charles C. Rutledge, M.D., Hazard. Alternate delegates are: Charles G. Bryant, M.D., Louisville; William W. Hall, M.D., Owensboro; and David B. Stevens, M.D., Lexington.

Annual Civil Defense Meeting Scheduled for Oct. 23-28

KMA members are invited to attend the 15th. Annual Meeting of the United States Civil Defense Council which will be held at the Brown Hotel in Louisville, October 23-28, 1966.

The program will include discussions on disaster medical care in such settings as recent tornados in Mississippi and Kansas, Community Communications for the health professions, community disaster plans and new emergency facilities available for use at times of disaster.

William T. Rumage, Jr., M.D., Louisville, Chairman of the KMA Disaster Medical Care Committee and Thomas S. Wallace, Jr., M.D., Director of the Jefferson County Health Department, 240 East Madison Street, Louisville, are serving on the Arrangements Committee. For further information, correspondence should be directed to Doctor Wallace.

Only Woman Vice-Pres. of AMA Dr. South Dies at Age 91

Lillian H. South, M.D., Louisville, the only woman physician to serve as vice president of the American Medical Association, passed away September 14 at the Pewee Valley Hospital at the age of 91.

Founder and past director of the laboratory services of the State Department of Health, Doctor South served as its director for 39 years, resigning in 1950 during the administration of Bruce Underwood, M.D., then Commissioner of Health. She was the first Kentuckian to receive a master's degree in public health.

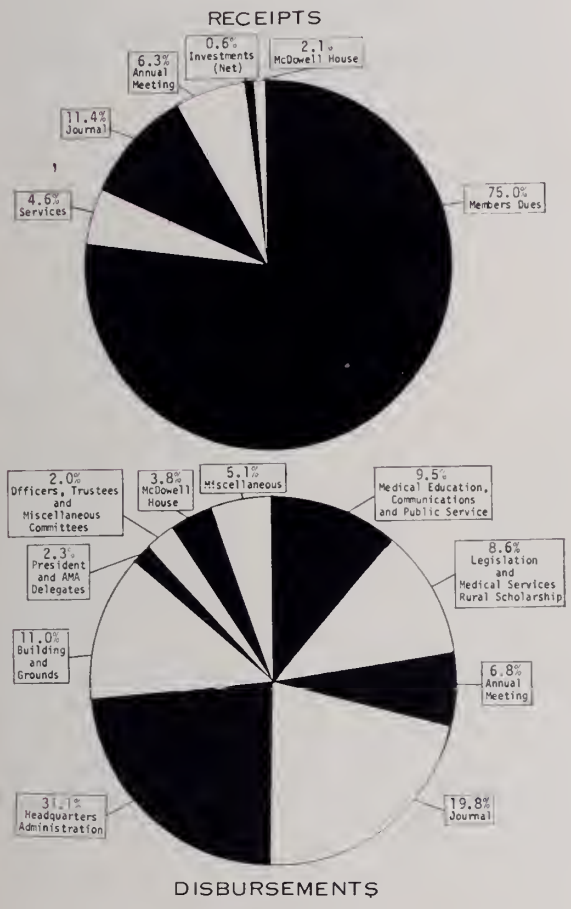
Doctor South graduated from the Woman's Medical College in Philadelphia in 1904. A native of Bowling Green, she served under three health commissioners, Arthur T. McCormick, M.D., Philip E. Blackerby, M.D., and Doctor Underwood.

No Position Taken on Charter

Inquiries have been made as to the Association's position on the proposed new Constitution for Kentucky, which will be voted on in November. The KMA Board of Trustees accepted a recommendation of the Council on Legislative Activities that no position be officially taken by the Board. Whether to support or not to support the proposal was left to the discretion of the individual physician.

Graph Demonstrates Distribution Of KMA Funds

Sources of income and the way its funds are disbursed by the Kentucky Medical Association are shown on the pie-shaped graphs below. These graphs, prepared by the Association's auditors, are based on the 1965-66 fiscal year. If members have any questions, they are urged to contact the Headquarters office.



Blue Shield Conference Planned October 10-11 in Chicago

"A Look Back . . . A Look Ahead" is the theme of the 1966 Blue Shield Annual Program Conference at the Drake Hotel, Chicago, on October 10-11, according to an announcement from D. Lane Tynes, Louisville, executive director of Kentucky Physicians Mutual, Inc.

Among featured speakers at the two-day conference are: Charles L. Hudson, M.D., Cleveland, Ohio, president of the AMA; Samuel R. Sherman, M.D., San Francisco, Cal., chairman AMA Council on Legislative Activities; H. Philip Hampton, M.D., Tampa, Fla., member, AMA Committee on Welfare Service; and Ernest B. Howard, M.D., Chicago assistant executive vice president, AMA.

Paul I. Hoagland, M.D., Pasadena, Cal. president of the National Association of Blue Shield Plans, will preside at the meeting. Carl R. Ackerman, M.D., Glen Cove, N.Y., chairman of the Board, National Association of Blue Shield Plans, will present the 1966 Norman A. Welch, M.D., Memorial Award. The conference, sponsored by the National Association of Blue Shield Plans, will start with registration at 8 on Monday, October 10.

Health Facilities Council Set Up In Louisville Area

The Louisville Area Health Facilities Council, a 35-member health-planning council, was scheduled to be incorporated as the Journal went to press. The revised council, which has undergone more than three years of planning and debate, has the approval of the Jefferson County Medical Society and the Louisville Chamber of Commerce according to Charles Kane, temporary council president.

N. I. Handleman will represent the Jefferson County Medical Society on the Council. In addition to 15 representatives of hospital boards of directors, the council will consist of five representatives of allied institutions including U of L and the local medical society.

AMA Sponsored Group to Meet

KMA members are invited to the First National Congress on Socio-Economics of Health Care, under the sponsorship of the Council on Medical Service and Division of Socio-Economic Activities of the American Medical Association, which will meet on January 22 and 23, 1967, in Chicago.

The Congress will bring together authorities from medicine, health administration, education, social sciences, community planning and other related fields, to discuss the various facets of the organization and delivery of health services. The subject matter of the discussions will be of special interest to doctors, who will be called on in the future to provide leadership in this area.

Dr. Witten Speaks in Austria

Carroll Witten, M.D., Louisville, was scheduled to deliver two addresses starting September 12, at the International Congress on Medicine at Salzburg, Austria. Doctor Witten, president-elect of the American Academy of General Practice, will give his address in English and then in German.

Annual Meeting News in Nov.

Since the 1966 Annual Meeting was held this year after the deadline for the October issue of The Journal, it was not possible to include a report of the meeting. Full coverage of the meeting will be carried in the November Journal. A digest of the proceedings of the House of Delegates meetings will appear in the December Journal.

Consultant's Implementation of Title XVIII-B Explained*

"Medicare" Part B will be administered in Kentucky by the Metropolitan Life Insurance Company of New York. It is the intermediary or "carrier". In other states the program will be carried out by this or other agencies. The central office in Kentucky is at 1218 South Broadway, Lexington under the direction of Mr. Donald Smith and Mr. Davies.

A summary of what "Medicare" means for all of us has been published by the AMA under the title: "Medicare and the Physician—Questions and Answers—On Public Law 89-97".

If you haven't read this by all means send to the AMA, get a copy and do so.

The heart of it may be summarized: the physician has three choices in his relation to Medicare—

1. He may ignore it.
2. He may sign in the space provided on the forms agreeing to "accept an assignment". This is a contract binding him not to charge more than his "usual and customary fee" and 80% of this will be paid direct to the physician after the annual $50.00 "deductible" has been paid to the "carrier" by the patient.
3. He may refuse to "accept an assignment" but will fill out his patient's forms or send his itemized bill so that Medicare will pay to the physician 80% of **what Medicare considers** to be his usual and customary fee. He may charge anything above this he chooses and this will be a private business between him and his patient.

Thus we see that Medicare is not setting the fee but only setting how much of it the "carrier" will pay.

This brings us to a brief statement of my private contract with "Medicare". I have accepted the position with retainer salary to act as a consultant to the State office in Lexington in cases where the size of fee cannot be settled. I am to **advise** not **decide** in the necessity for and length of treatment in any questioned case.

For patients in a hospital these matters will be decided by Medicare under Part A with the advice of the hospital staff committee. This committee, technically known as the "Utilization Committee", each hospital will choose from its own staff. I may or may not be asked to sit in on such meetings. I do not yet know. If I am present I would express no opinion unless asked.

To prepare myself for this work, I have read all the printed matter available, have talked with the KMA office in Louisville, with several of my professional friends over the State, with the local administrators of Medicare, with the Chief Medical Director of the Metropolitan, and have made a trip to Chicago and talked with officers of the AMA. Incidentally, I interpret the AMA to say in effect, "We may not like it but it's the law and we will go with it but will keep alert for defects as they may appear. We are opposed to the setting of fees, we are opposed to any financial settlement except directly from patient to doctor."

I will try to be fair when my advice is asked and will give no advice until I have had a personal interview with the physician whose fee or treatment is in question. I am sure that sometimes a charge above his usual and customary fee will be justified.

* Francis Massie, M.D., Lexington, has been appointed to serve as a consultant to the Metropolitan Life Insurance Company, "carrier" under PL 39-97 Title XVIII Part B.



Prior to the official opening of the 1966 Kentucky State Fair, the above picture was made of the KMA exhibit, "Life Begins". It is estimated that more than 8,000 persons went through this exhibit, which was described as "one of the busiest" at the Fair.

Symposium on Breast Tumors To Be Held on Nov. 4

The "Symposium on Diagnosis of Breast Tumors" is scheduled Friday, November 4, in Louisville, under the sponsorship of Louisville General Hospital and the University of Louisville School of Medicine.

The morning session, moderated by Raul Gonzalez, M.D., will include panel discussions concerning "Pre-Malignant Breast Diseases" and "Surgeons Look at Mammography".

The afternoon session, moderated by Alfred O. Miller, M.D., will include lectures on the history and the technique of mammography, and a panel discussion entitled "Horizons in Diagnosis of Breast Diseases".

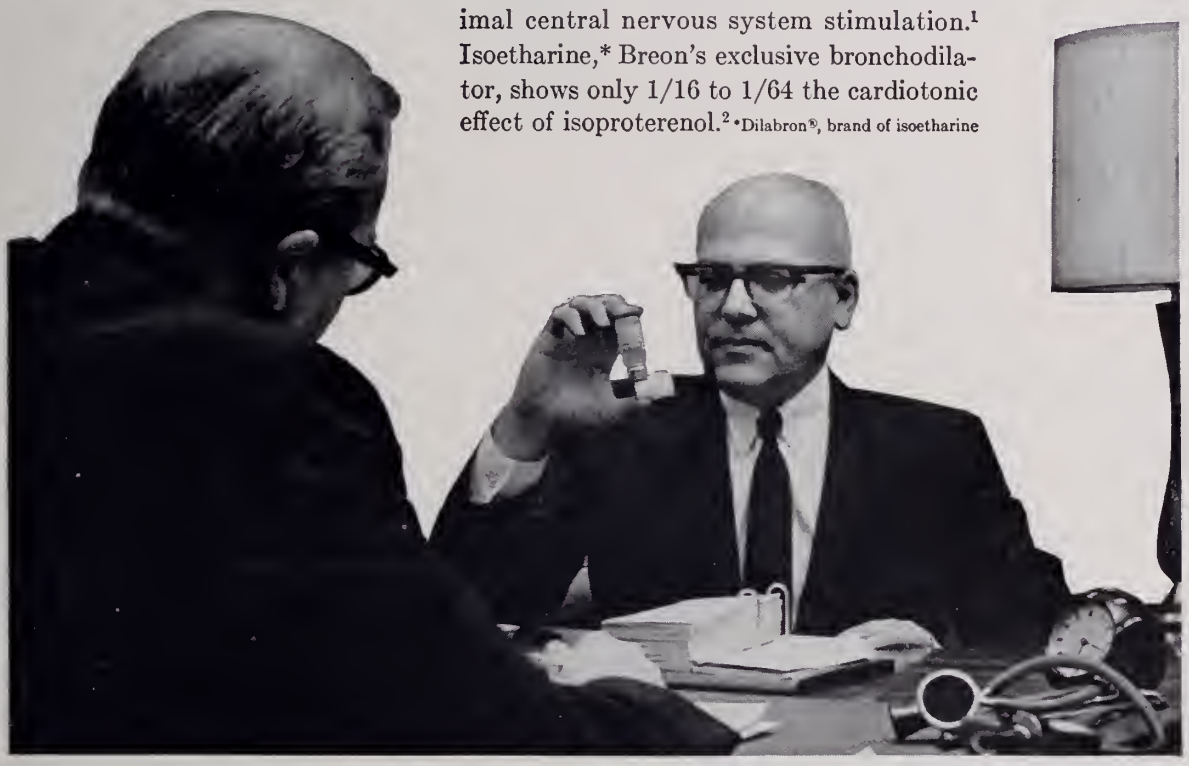
Hospitals Get New President

Maurice K. Henry, a Middlesboro, Kentucky, publisher, has been elected the interim President of Appalachian Regional Hospitals, a non-profit corporation which operates nine community hospitals in Eastern Kentucky, Virginia and West Virginia.

Garvice D. Kincaid, Chairman of the Board of Trustees, announced in Lexington that Henry, a trustee and Treasurer of ARH since 1963, will serve until a permanent president is found. Henry is taking the place of Karl S. Klicka, M.D., who resigned to become chief executive officer of the Peoples Community Hospital Authority of Wayne, Michigan,

"I like Bronkometer... I breathe better... don't get the jitters."

Patients feel relaxed with Bronkometer. Its bronchodilator-decongestant action has minimal central nervous system stimulation.[1] Isoetharine,* Breon's exclusive bronchodilator, shows only 1/16 to 1/64 the cardiotonic effect of isoproterenol.[2] *Dilabron®, brand of isoetharine



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COMPOSITION: Bronkometer delivers at the mouthpiece 200 metered doses of: 350 mcg isoetharine methanesulfonate (0.6%); 70 mcg phenylephrine HCl (0.125%); and 30 mcg thenyldiamine HCl (0.05%) with saccharin, menthol and fluorochlorohydrocarbons as inert propellants. Preserved with ascorbic acid 0.1% and alcohol 30%.

RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

PRECAUTIONS: Bronkometer is unusually free from cardiovascular and other side effects, but the usual precautions associated with sympathomimetic amines should be observed. Bronkometer should not be administered simultaneously with epinephrine or similar compounds because of the possibility of tachycardia, although it may be alternated with these agents. Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve and in individuals sensitive to sympathomimetic amines.

SUPPLIED: 10 ml pressurized aerosol vials complete with measured dose valve and oral nebulizer.

References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.

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Lexington VA Gets Chief

James J. Rams, M.D., has been appointed assistant chief of the surgical service at the Veterans Administration Hospital in Lexington. Doctor Rams has served as assistant professor in the Department of Surgery at the University of Chicago. He graduated from Georgetown University School of Medicine in 1955, interned at the University of Chicago Clinics, and received his residency training in the Department of Surgery, University of Chicago.

Nov. Marks Farm-City Week in Ky.

November 18-24 has been set for Farm-City Week in Kentucky for 1966. All KMA members are encouraged to participate in the 12th annual observance designed to build better understanding and appreciation of the interdependence of Kentucky's rural and urban population.

Farm-City Week presents an opportunity for farmers and city people to become better acquainted, realize each others problems and work toward their solution. Each KMA member is urged to take an active role in Farm-City Week programs that include such projects as joint visits, seminars, pageants, fairs, civic and social events.

New Nursing Director Named

Miss Mary Margaret Walters, a former president of the Kentucky Nurses Association, has been named director of nursing at Louisville General Hospital. She has served as assistant director of nursing service at both St. Joseph Infirmary and Methodist Evangelical Hospital. Miss Walters is a graduate of the Good Samaritan Hospital Nursing School at Lexington.

Surgeons Awarded Grant

The American College of Surgeons has been awarded a three year grant of $275,000 by the John A. Hartford Foundation, Inc. of New York, for support of the Field Program in Trauma—to improve care of the injured patient. The Board of Regents accepted the grant, the third of its kind, to carry out various projects in educating the public on comprehensive emergency care.

Medical Hazards of Blood Transfusions

(Continued from Page 867)

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Members of the KMA Headquarters staff are shown above assembling and stuffing the approximately 300 mimeographed pages that comprise 1966 Packet of Reports to KMA officers and delegates for the 1966 Meeting.

Governor Praises Dr. Norfleet

Carl Norfleet, M.D., Somerset, received a letter from Governor Edward T. Breathitt praising the doctor's assistance in the founding of the state's TB hospitals, and stating that often the efforts of such men as Doctor Norfleet are quickly forgotten. Doctor Norfleet is a member of the Rural Kentucky Scholarship Board of Trustees and is a former member of the Council (now Board of Trustees) of KMA.

KMA Council and Committee Reports

Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman, National Affairs
J. Campbell Cantrill, M.D., Georgetown, Chairman, State Affairs

KMA Headquarters Office **Thursday, July 21, 1966**

The KMA Council on Legislative Activities recently held its seventh meeting of this associational year.

The purpose of this meeting was to formulate and approve the Council's final report to the 1966 session of the House of Delegates and take action on the report of the Committee on Cults, which serves under this Council.

In addition, a number of national legislative matters were discussed and recommendations concerning direct billing and other medical legislation were submitted to the Board of Trustees.

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CONSIDER: an exceptionally high cure rate in susceptible infections

The rationale: When combined, Erythrocin and the trisulfapyrimidines (triple sulfas) are indicated in infections that are more susceptible to the combination than to either agent alone. Such conditions are usually found in urinary, lower respiratory tract and chronic ear conditions.

The results: Clinical studies involving 142 young patients showed *an overall cure rate of 96.5%*. Side effects were experienced by only four of the patients.

The acceptance: The majority of the 142 patients studied expressed a definite liking for the products. *There were only two refusals.* An independent taste-test with 50 healthy children further substantiated the excellent acceptability of the orange-flavored forms.

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ERYTHROCIN®-SULFAS
Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

ABBOTT

NEWS ITEMS

Abraham M. Gordon, M.D., Louisville, has just returned from a trip to West Berlin, Germany, where he addressed the Twentieth International Congress on the Study of the History of Medicine. The topic of his speech was Abraham Lincoln.

Patrick P. Galla, M.D., has started to practice in association with Robert R. O'Conner, Louisville, Specializing in psychiatry. Doctor Galla graduated from Georgetown University in 1954. He interned at the Ohio Valley General Hospital, Wheeling, West Virginia, and did his residency at the University of Louisville.

Charles Howard, M.D., general practitioner, is now practicing in association with the Fuller-Morgan Hospital and Clinic, Mayfield. Doctor Howard graduated from the St. Louis University Medical School in 1965, and did his internship at the St. Louis County Hospital.

Russel L. Hall, M.D., health officer for Floyd County during the past five years, began a year's sabbatical on September 7. Doctor Hall will spend the year studying at the University of North Carolina.

Surjeet Singh Dhanjal, M.D., has been named director of pediatric education and training at St. Joseph's Infirmary, Louisville. Doctor Singh received his degree in medicine at the University of Madras in India. For the past three years, he has been chief resident in pediatrics at Children's Hospital, Louisville. Doctor Singh is certified by the American Board of Pediatrics.

Omar C. Amstutz, M.D., Irvine, has retired from active practice. Doctor Amstutz is the president of the Estill County Medical Society. He graduated from the Ohio State University College of Medicine in 1928. Doctor and Mrs. Amstutz plan to remain in Irvine.

Verne V. Eskridge, M.D., formerly a general practitioner in Ownesboro, returned in July to open an office for the practice of psychiatry. A 1951 graduate of the University of Louisville School of Medicine, Doctor Eskridge re-enrolled in 1963 as resident psychiatrist. During the years 1955-66, he was a fulltime faculty member of the Medical School's psychiatry department. Doctor Eskridge also serves as special consultant to the commissioner of the Kentucky Department of Mental Health.

Murray A. Diamond, M.D., who served as the head of U.S. Public Health Hospital in Lexington until 1962 has retired. Doctor Diamond also served as associate professor of clinical psychiatry at the University of Kentucky.



The "Socio-geographic" mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.[3-8] Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."[3]

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action confirmed by gastric analyses and x-ray evidence of clinical effectiveness.[3,7,9-12] Relieves pain with "impressive" promptness.[8] Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, belching and other ulcer symptoms.[7] Suppression of nocturnal pain is "outstanding."[13] Maximally effective doses may be given with minimal side reactions, and the incidence of unwanted anticholinergic effects is negligible.[3,7-14]

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(brief summary follows)

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Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.
Precautions: Administer with caution in the presence of incipient glaucoma.
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.
Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*
Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.
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Ky. Physicians in the Armed Forces

Forrest Wayne Calico, M.D., Lexington recently left for Washington, D.C. to report for service at Andrews Air Force Base where he has received a captain's commission. Doctor Calico is a 1966 graduate of the University of Kentucky School of Medicine.

Ted J. Sanders, M.D., Flatwoods, reported to the Key West, Fla. Naval Base, where he will have a six week's indoctrination period before assigned to duty. Doctor Sanders, a 1962 graduate of the University of Louisville School of Medicine, was classified as Lieutenant commander.

David L. Lawrence, M.D., Jamestown, reported to Camp Lejeune, N. C., on September 1. He will be stationed at the naval hospital there and will have the rank of lieutenant. After serving two years, Doctor Lawrence plans for return to Jamestown.

Ray A. Cave, M.D., Leitchfield, reported August 1, at Fort Sam Houston, Texas for service in the U.S. Army. Doctor Cave, a 1960 graduate of the University of Louisville School of Medicine, has been a general practitioner in Leitchfield for the past five years.

COUNTY SOCIETY REPORTS

Mason

President, John T. Teegan, M.D.; secretary-treasurer, Claude E. Cummins, Jr., M.D.; delegate, Harold N. Parker, M.D.; alternate Robert M. Blake, M.D. All are from Maysville.

Union

President, George Welker, Jr., M.D.; vice-president, J. P. Welborn, Jr., M.D.; secretary-treasurer, B. E. Elliott, Jr., M.D., all of Morganfield. Delegate, Jerry B. McKenny, M.D.; alternate, Wallas N. Bell, M.D., both of Sturgis.

Three Kentucky physicians, Walter S. Coe, M.D., editor of the Journal of the Kentucky Medical Association, John S. Llewellyn, M.D., and George W. Pedigo, Jr., M.D., all of Louisville, are scheduled to participate as delegates to the Annual Assembly of the American Heart Association when it meets in New York on October 23-25.

Donald L. Hartman, M.D., has become associated with Trover Clinic, Madisonville, limiting his practice to dermatology. Doctor Hartman graduated from Temple University in 1961. He did his internship at the University of Tennessee Memorial Hospital, and his residency at Geisinger Medical Center.

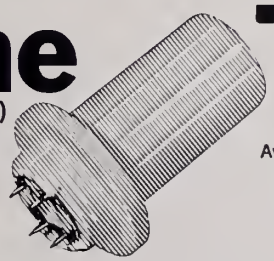
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In Memoriam

NEIL E. TAYLOR, M.D.
Newport
1892-1966

Neil E. Taylor, M.D., a retired Newport general practitioner, died on August 22 at Fort Thomas Veteran's Administration Hospital where he had been a patient for four years. A 1914 graduate of the Eclectic Medical College, Doctor Taylor was a member of the KMA and the Campbell-Kenton County Medical Society. He was a veteran of World War I.

KENNETH W. BRUMBACK, M.D.
Cynthiana, Ky.
1900-1966

Kenneth W. Brumback, M.D., a general practitioner and otolaryngologist in Cynthiana for 36 years, died Tuesday, August 30, in Harrison Memorial Hospital after a six-week illness. A native of Covington, he graduated from the University of Cincinnati College of Medicine in 1928. During World War II, he served as a major in the medical corps. He was a member of the Masons and past exalted ruler of the Cynthiana Elks Lodge.

W. S. FLOWERS, M.D.
Columbia
1883-1966

W. J. Flowers, M.D. 82, retired general practitioner died August 3 in Columbia after an illness of several years. Doctor Flowers graduated in 1910 from the University of Louisville Medical School. He was past president of the Adair County Health Board and Medical Society. He was a member of the American and Kentucky Medical Associations. He had practiced in Adair and adjoining counties for 27 years. He retired 9 years ago.

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CONSIDER **DEXAMYL**® FIRST
brand of dextroamphetamine sulfate and amobarbital

Often within the hour, 'Dexamyl' works to help dispel such symptoms as apathy, pessimism, loss of interest and initiative, and lack of ability to concentrate.

Formulas: Each 'Dexamyl' Spansule® capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*.

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Do not use in patients taking MAO inhibitors. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester. *Side effects:* Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

SK&F SMITH KLINE & FRENCH LABORATORIES

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

CHARMS THE HYPERACTIVE COLON



CANTIL®

(mepenzolate bromide)

helps restore normal motility and tone

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide) —25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL —containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE

PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

DACTILASE®

Each tablet contains:
Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
Standardized amylolytic enzyme, 15 mg.;
Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.



GERILID™

Each chewable tablet contains:
nicotinic acid (niacin) 75 mg. and
aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

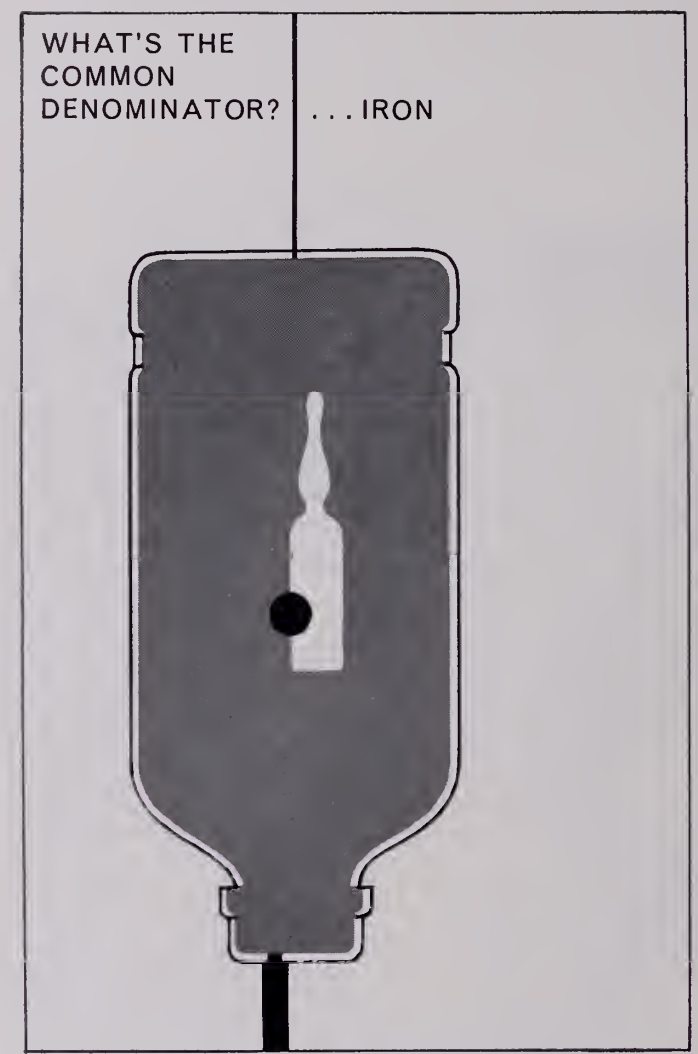
Supplied: Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

In fact, there's as much iron...250 mg. ...in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron...or orally administered iron proves ineffective or impractical...or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves.



IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses. Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides*. Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day*.



METAHYDRIN®
(trichlormethiazide)
oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY



Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

When depressed patients say:





"I'm tired all day long"

NORPRAMIN®
(desipramine hydrochloride)
non-sedating · rapid-acting
ANTIDEPRESSANT

helps restore normal patterns of sleep and activity

Norpramin (desipramine hydrochloride) often reverses the signs and symptoms of depression including sleep disturbances feeling of sadness, guilt, anxiety, worthlessness and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, active and less weighed down by their problems.

Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

PRODUCTS FOR PATIENTS YOU SEE EVERY DAY LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



PEDIATRIC PIPTAL® WITH PHENOBARBITAL

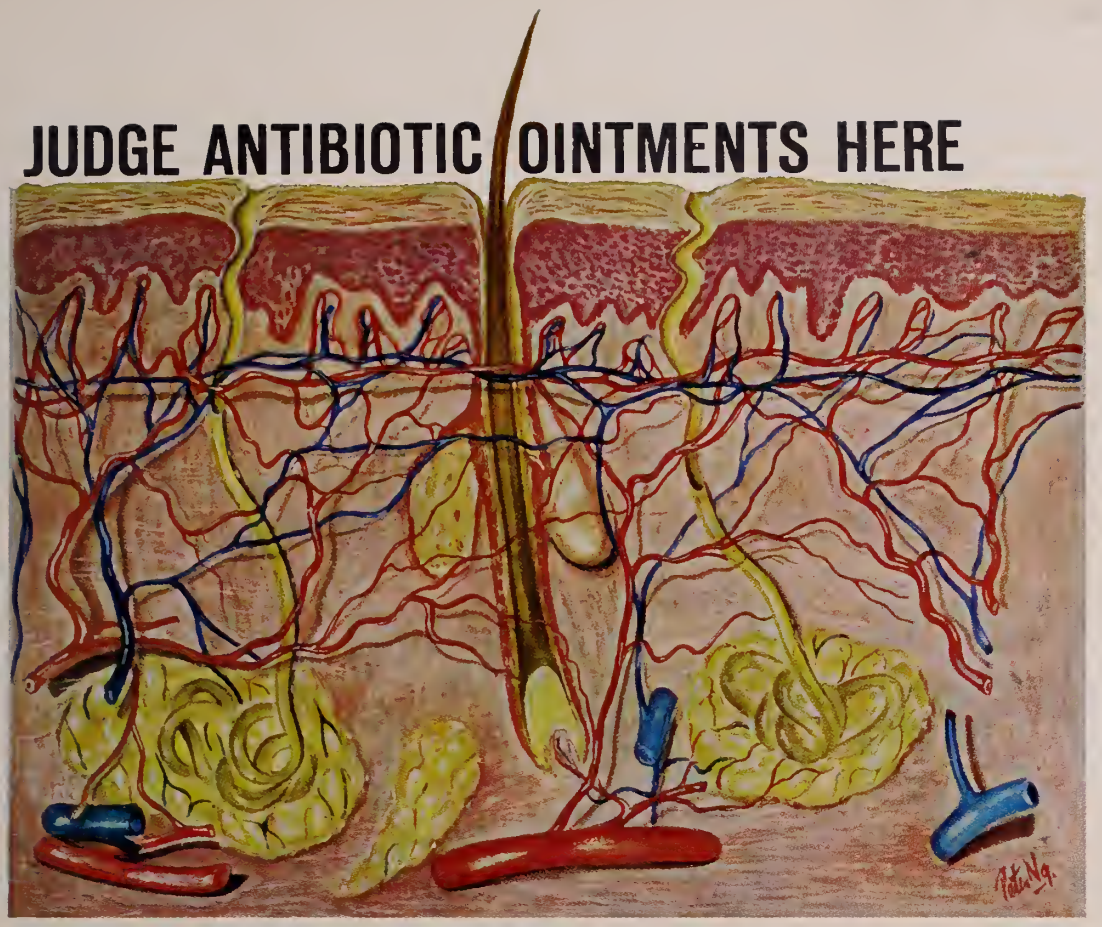
each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

new



a new formulation that relieves pain in tension headache and neuralgia

Dialog is a combination of 15 mg allobarbital and 300 mg acetaminophen. Allobarbital, a proven barbiturate, provides desirable sedation in patients experiencing pain and discomfort. Acetaminophen is a nonsalicylate analgesic-antipyretic, well tolerated and useful in a wide range of mildly painful and febrile conditions.

Dialog is well tolerated, even by those sensitive to aspirin. It is nonirritating to the gastrointestinal tract and, in recommended dosage, has no adverse effects on the kidneys.

- Raises the pain threshold
- Suppresses the pain-producing mechanism
- Reduces emotional tension

2/3449 MK-3



Dialog™

(allobarbital and acetaminophen CIBA)

Indications: For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

Contraindication: Not recommended during pregnancy.

Caution: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

Side Effects: Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

Dosage: *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* ½ to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

Supplied: *Tablets* (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

For your convenience—prescription-size bottle of 30.

CIBA Pharmaceutical Company, Summit, N.J.

CIBA

Winthrop announces new WinGel®

ANTACID TABLETS AND LIQUID

For peptic ulcer, gastric hyperacidity, gastritis

Each WinGel tablet or teaspoon (5 ml.) contains 410 mg. of combined, highly reactive, short polymer, aluminum and magnesium hydroxides **stabilized with hexitol.**

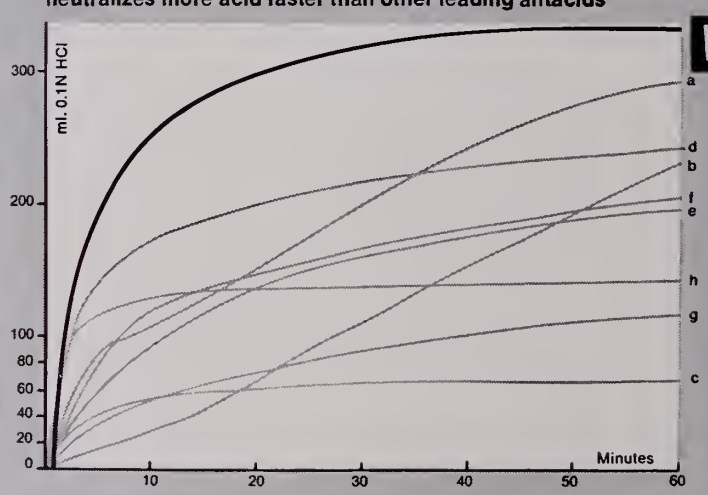
Neutralizes 300 times its active-ingredient weight in gastric acid for fast, long-lasting relief

Gastric or duodenal ulcer, acute or chronic gastritis, gastric hyperacidity...wherever there is "acid overflow" new WinGel can provide faster, longer, more complete neutralization.

In recent laboratory comparisons* with eight other leading antacids, new WinGel tablets not only neutralized more hydrochloric acid per active-ingredient weight, but neutralized it faster and longer than all other antacids tested.

Pleasant pink in color, WinGel is delicately mint flavored with a smooth-as-cream texture—qualities sure to please the patient on long-term therapy. New WinGel is also specially formulated to avoid constipation or diarrhea.

New WinGel neutralizes 300 times its active-ingredient weight in 0.1N hydrochloric acid—neutralizes more acid faster than other leading antacids



Rate of 0.1N hydrochloric acid neutralization at pH 3.5 and 37° with WinGel and eight other leading antacid tablets—*in vitro*. Samples equaled the weight of tablet material containing 1.0 Gm. active ingredients.*

*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

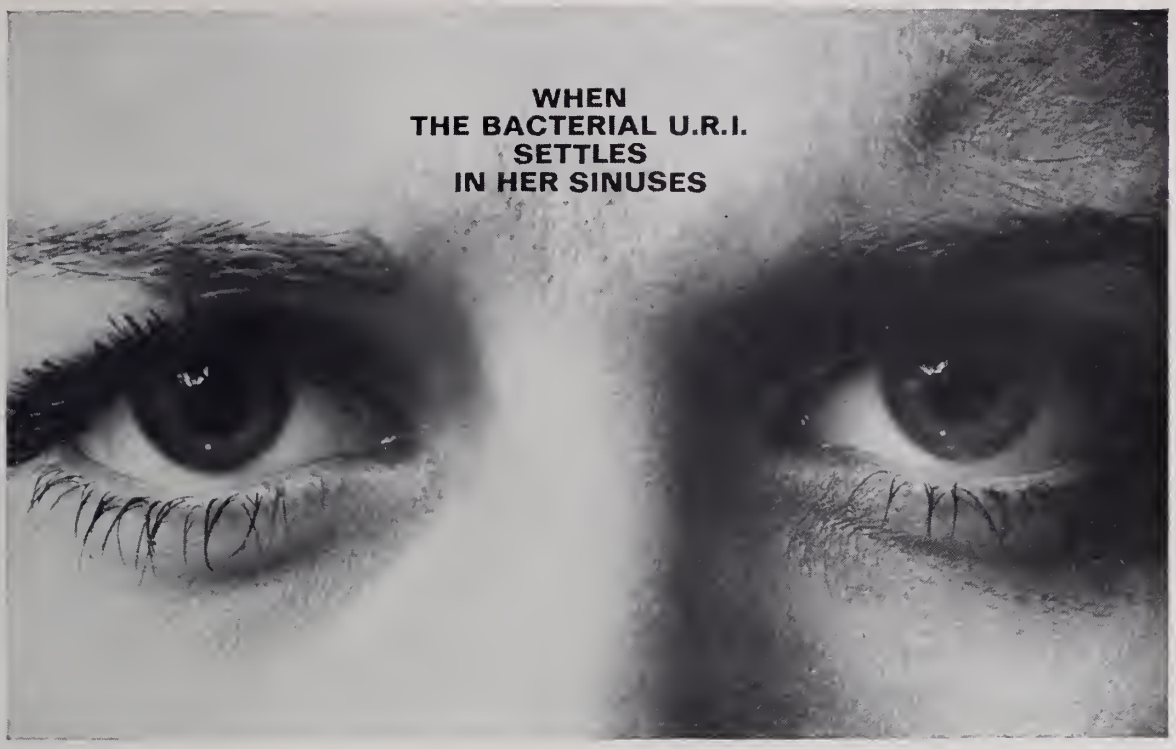
Dosage: Peptic ulcer or gastritis—from 2 to 4 teaspoons of WinGel liquid or 2 to 4 tablets chewed or allowed to dissolve in the mouth every two to four hours. **Gastric hyperacidity**—2 tablets or teaspoons about ½ to one hour after meals as needed; children from 7 to 14 years of age, 1 or 2 tablets or 1 or 2 teaspoons of liquid as needed.

How Supplied: Liquid in bottles of 8 fl. oz. and 1 pint. **Tablets** in cellophane strips, boxes of 50 and 100. (One teaspoon of WinGel liquid is equivalent to one WinGel tablet in acid-combining capacity.) WinGel, trademark reg. U.S. Pat. Off.

Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Finally — a taste your patients will truly like

(1058H)



ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg
Phenacetin	120 mg
Caffeine	30 mg
Salicylamide	150 mg
Chlorothen Citrate	25 mg

The patient can feel better while getting better. ACHROCIDIN brings the treatment together in a single prescription—prompt symptomatic relief together with early, potent control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract.

Contraindication—History of hypersensitivity to tetracycline.

Warning—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

608-6-3393

Frankly, most antihypertensives are pretty good if you give an adequate dose. I'm looking for one with a simple regimen so that mix-ups in doses and therefore the chance of side effects are minimized.



Regroton®

chlorthalidone 50 mg. reserpine 0.25 mg.

1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy

MEN'S SHOP



. . . in the SOUTHERN OPTICAL BUILDING, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Contact Lens and Artificial Eye Service on Opthamologist's Prescription Only

SYMPOSIUM ON ADOLESCENCE

NEW ORLEANS, LOUISIANA **DECEMBER 1-3, 1966**

Approved for 15 hours credit by the American Academy of General Practice

Sponsored by the

DIVISION OF PSYCHIATRY and COMMUNITY MENTAL HEALTH CENTER OF TOURO INFIRMARY
supported by a National Institute of Mental Health Grant

GUEST LECTURERS INCLUDE:

Dana Farnsworth, M.D., Director of Student Health Services at Harvard University, Cambridge, Mass.
Irvin Kraft, M.D., Professor of Child Psychiatry at Baylor Medical School, Houston, Tex.
John Schimel, M.D., Associate Director of William Alanson White Institute of Psychiatry Psychoanalysis and Psychology, New York, N. Y.
George Tarjan, M.D., Professor of Psychiatry and Program Director of Mental Retardation Project at University of California in Los Angeles, Calif.
Carroll Witten, M.D., President-Elect of American Academy of General Practice, Louisville, Ky.

AMONG TOPICS TO BE DISCUSSED:

"The Physician's Role in Mental Retardation"
"Parents of Problem Children"
"Handling of Adolescents by General Practitioners"
"Sexual Morality—A College Dilemma"
"Drugs in the Treatment of Children and Adolescents"
"Learning Problems of the Adolescent"
"Adolescence and Social Mores"
"Talking About Sex with Adolescents"
"Religious-Psychological Conflicts"

Symposium will be held at the Fontainebleau Motor Hotel, 4040 Tulane Ave. Eorly hotel reservations ore recommended.

Gene L. Usdin, M.D.
Director of Psychiatric Services
Touro Infirmary
1400 Foucher Street
New Orleans, Louisiana 70115

Enclosed is my registrotion fee of $20 for the SYMPOSIUM ON ADOLESCENCE to be given December 1-3, 1966 at the Fontoinebleau Motor Hotel. (Checks should be made payable to Touro Infirmary.)

Name _____

Address _____

_____

Founded in 1904

HIGHLAND HOSPITAL, INC.

ASHEVILLE, NORTH CAROLINA
Affiliated with Duke University





A non-profit, psychiatric institution, offering therapeutic milieu, group and individual psychotherapy, and standard somatic treatments. Limited day-patient and out-patient services. The hospital is located in a 75-acre park amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

Contact: Medical Director, Highland Hospital, Asheville, N.C. 28801

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

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Professional Protection Exclusively since 1899

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Mailing Address: P.O. Box 20065, Louisville 40207

fall 1966

DORSEY Season

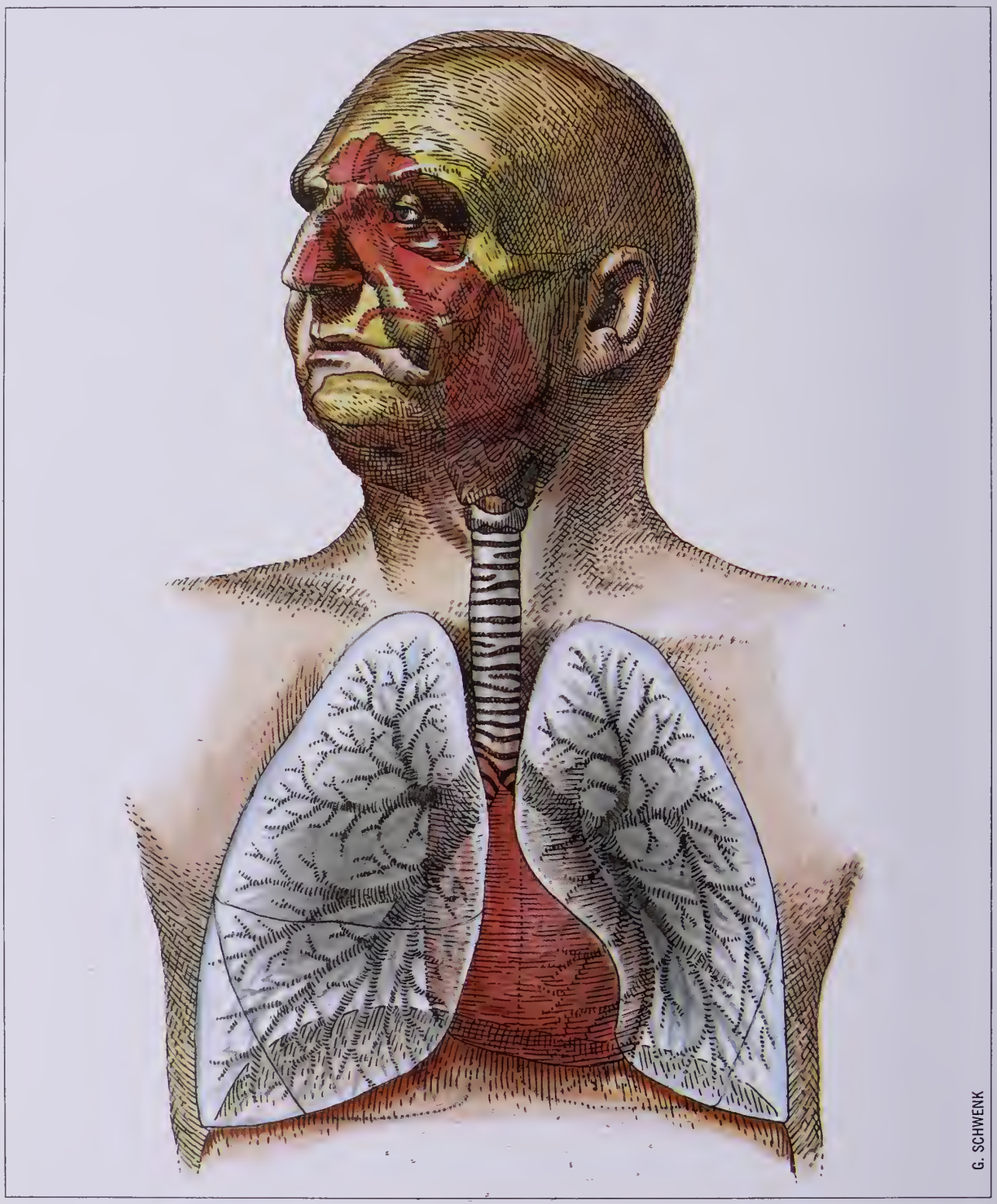
A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.



this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to broncho-pneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

The anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

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comforting thing
to know



For postnasal drip, clogged ears
and stuffed and runny noses

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keeps patients comfortable 'round the clock. 24-hour decongestion on just a single tablet dosed morning, mid-afternoon and at bedtime. Patients regain senses and can breathe, smell and taste again.

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Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
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Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.

Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

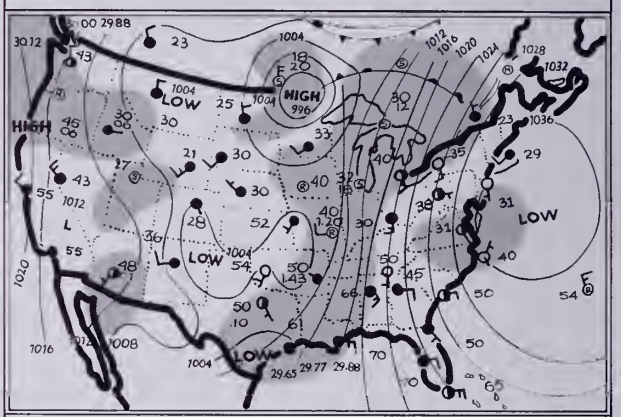
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

References 1. Steiglitz, Edward J., Geriatric Medicine, Medical Care of Later Maturity, 3rd edition, J. B. Lippincott Co., Philadelphia, 1954. 2. Norman, J. R., Schweppe, I. H., Salazar, E. and Knowles, J. H., Lung Volumes and Aging, Journal of the American Geriatrics Society, 12, pp. 38-47, January 1964. 3. Penman, Robert W. B., Hypoxia and Respiratory Failure, Geriatrics, 18, 807-814, November 1963. 4. Middleton, William S., Some Medical Dissections on Aging, Geriatrics, 18, 168-73, March 1963. 5. Cole, M. B. and Roberts, F. E., Clinico-Pathologic Study of Emphysema, Journal American Geriatrics Society, 12: 415-419, May 1964. 6. Horton, Glenn, Testing of Pulmonary Function, Geriatrics, 17:73-81, February 1962. 7. Banyai, Andrew L., Cough and its Management in Elderly Patients, Geriatrics, 14:621-630, October 1959. 8. Howell, T. H. and Piggot, A. P., Morbid Anatomy of Old Age, Geriatrics, 8:267-72, March 1953.

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Tussagesic® provides up to 24-hour coverage of the tough cold with a single timed-release tablet dosed morning, midafternoon and at bedtime. Coughs are broken up, runny and stuffed noses are cleared and pain is relieved.

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Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: Patient should not drive a car or operate dangerous machinery if drowsiness occurs. Except under professional care, do not give to patients under 12 yrs. or those who have persistent cough, high fever, heart or thyroid disease, hypertension or diabetes or use for more than 10 days.

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when congestion is complicated by sulfa-susceptible bacterial invaders in the upper respiratory tract...



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Each tablet contains: Triaminic® 25 mg. (phenylpropanolamine hydrochloride 12.5 mg., pheniramine maleate 6.25 mg., pyrilamine maleate 6.25 mg.); Trisulfapyrimidines, U.S.P. 0.5 Gm. (sulfadiazine 0.167 Gm., sulfamerazine 0.167 Gm., sulfamethazine 0.167 Gm.)

PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. INDICATIONS: For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. DOSAGE: Adults: 2 to 4 tablets initially, followed by 2 tablets every 6 hours. Medication should be continued until patient has been afebrile for 3 days. ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. CONTRAINDICATIONS: Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. PRECAUTIONS: Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. ADVERSE REACTIONS: As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. PACKAGE INFORMATION: Trisulfaminic Tablets: Supplied in bottles of 100 tablets. CAUTION: Federal law prohibits dispensing without prescription.

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Well tolerated. Tetrex (tetracycline phosphate complex) is well tolerated. Gastrointestinal side effects are few; photodynamic reactions are extremely rare.

More of the active antibiotic in the blood. The basic tetracycline in Tetrex (tetracycline phosphate complex) is less bound to serum protein than is demethylchlortetracycline.[1] Result: Tetrex (tetracycline phosphate complex) provides a higher percentage of active antibiotic in the blood.

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BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms. *Contraindications:* The drug is contraindicated in individuals hypersensitive to tetracycline. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Mycotic or bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. *Usual Adult Dose:* 500 mg. b.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuharic, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

*Each bidCAP contains: Tetrex (tetracycline phosphate complex equivalent to 500 mg. tetracycline HCl activity).

When thiazide or reserpine alone won't keep



Establish and maintain early, more decisive control of blood pressure

DIUTENSEN®-R

Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

When blood pressure won't stay down despite initial therapy—when complaints of headache, fatigue or dizziness are often voiced—it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine *plus* cryptenamine—a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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Automated Utilization Review

A NEW program to assist hospital staffs in utilization review began operation in Kentucky in July. The program takes advantage of modern data processing equipment to supply information to hospital utilization review committees.

The task confronting a review committee is sizable. It amounts in great part, to sifting through bulky hospital charts to retrieve certain key items of information. These specific facts when properly displayed can reveal significant trends and problems in patient care. Two serious draw backs to the process of reading each individual chart is, first, the enormous burden of work involved, and second, the process rapidly degenerates to a perfunctory scanning of superficial details which tends to overlook these significant patterns and trends.

The idea of a computerized hospital utilization review system for Kentucky hospitals came following a utilization seminar held in February in Louisville. The "Professional activity and medical audit program of the Commission on Professional and Hospital Activities of Ann Arbor, Michigan was described in detail. Much interest and enthusiasm was expressed by hospital authorities, however this established program was not able to accommodate the increased load of the many interested hospitals in Kentucky.

A committee representing the Kentucky Hospital Association, The Kentucky Medical Association and Kentucky Blue Cross was formed to study and develop a similar but less sophisticated service for hospitals in Kentucky.

Participating hospitals prepare a case abstract for every clinical record. Only a few minutes is needed for each chart, and the work is done by personnel in the medical record department, so no extra paper work is required of the physician. The information as entered on the abstract is ready for key punching to provide input to a computer in the Blue Cross office. Each hospital will receive monthly summaries and more comprehensive semiannual summaries. These will provide routine medical statistics as well as more specialized information for use of the utilization committees. The program will start out with a relatively simple abstract, however, it will lend itself well to various special studies after initial experience is gained. It is hoped that this service will greatly facilitate and simplify the work of utilization committees.

WILLIAM W. HALL, M.D.

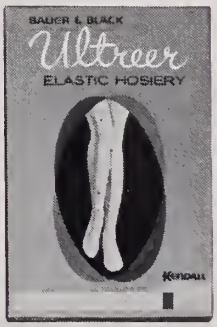
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That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

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You might also say that all interns aren't alike, either.





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WHY does a chair manufacturer create so many different styles of chairs?



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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #12-63. This 19-year-old, para O was admitted to the hospital 5/15/63 when approximately seven months pregnant with the complaint of gross hematuria that had persisted for 36 hours prior to admission. Her hospital chart was lost and all clinical information supplied is from the autopsy report.

Vital signs on admission were B.P. 120/80; T 98.8; and R 20. There were no abnormalities found on physical examination. Cystoscopic examination was performed and revealed gross blood coming from the ureters bilaterally. Retrograde pyelography was performed and the abnormalities interpreted as "pyelonephritis cystica, right kidney".

Laboratory studies included: Hemoglobin 5.9 grams %; Hematocrit 16%; WBC 9,000 with a differential of polys 63%, stab forms 2%, lymphs 26%, monos 8%, and a platelet count of 32,000. A bone marrow study was done 5/17/63. The impression was: accelerated erythropoiesis associated with a hemolytic anemia, response to therapy, or acute blood loss.

The non-platelet forming megakaryocytes were consistent with the thrombocytopenia. This pattern could be seen with thrombotic thrombocytopenic purpura.

Other laboratory studies included bleeding time four minutes; coagulation time four minutes, 14 seconds; VDRL non-reactive; total serum bilirubin 3.47 mg per cent, with 1.15 mg per cent direct reacting; icteric index 20 U. A repeat platelet count was 14,000. A prothrombin time was 86% of normal and SGO transaminase was 87 U. An LE preparation was negative.

Clinical Course

The patient had fever ranging from 99.2 to 99.9. She became disoriented and approximately 6 hours prior to death developed multiple petechiae on the skin. She experienced intermittent shock and died 5/17/63. Nothing is known of medications administered prior to or during the admission. Following death, an immediate hysterotomy was performed but the infant was stillborn.

Post-mortum Findings

At autopsy, the patient was noted to have small petechial hemorrhages on the skin of the face, head, neck, and extremities. There was serosanguineous fluid present in the pleural, pericardial, and peritoneal spaces. Petechial hemorrhages were noted in the subcutaneous fat and on the serosal surfaces. The heart weighed approximately 300 grams. The epicardium had multiple petechial and ecchymotic hemorrhages which extended into the myocardium. The gastrointestinal tract was noted to have petechial hemorrhages of the serosal surfaces.

The uterus had been opened by classic Caesarean incision. There were numerous hemorrhages involving the outer 2/3 of the myometrium. The endometrial cavity was lined by a slightly hyperemic surface.

In sectioning the brain, small petechial and ecchymotic hemorrhages were noted beneath the subarachnoid tissue. There was hyperemia of the pia-arachnoid. On sectioning the brain, no hemorrhages were noted. Examination of the kidneys revealed multiple, extensive, ecchymotic hemorrhages in the renal pelvis and calyces bilaterally.

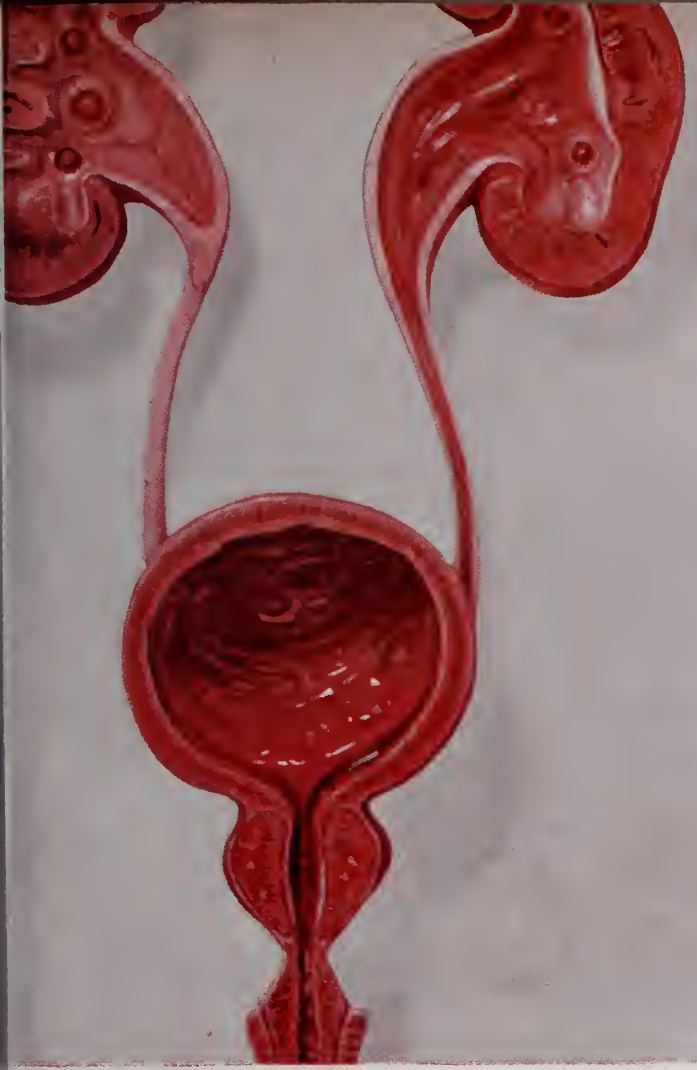
The final diagnosis: Thrombotic thrombocytopenic purpura with hemorrhages, extravasation, petechial and ecchymotic areas generally.

Comment

The Committee felt this was an indirect obstetric death and worth reporting since idiopathic thrombocytopenic purpura is an uncommon complication of pregnancy. However, secondary thrombocytopenic purpuras are more commonly encountered. These may be due to a wide variety of etiologic factors such as bone marrow depression due to drug therapy, the toxemias of pregnancy, hypofibrinogenemia related to placental abruption and a variety of the systemic disorders. The incomplete information available to the committee in this case due to the loss of the hospital record, once again points up the necessity for complete and accurate reporting if the committee is to effectively and completely study each case. Since there is no evidence of co-existing systemic disease or other complications of pregnancy, the assumption is made that this is a case of idiopathic thrombotic thrombocytopenic purpura. It has been reported that the maternal mortality in this disease is about 2% and the perinatal mortality is 15%.(1) Patients with idiopathic thrombocytopenic purpura should be under careful medical supervision, as was this patient. Adrenal cortical steroids have produced inconsistent results in various investigations. If uncontrollable bleeding occurs or major surgery is to be performed, transfusion by fresh whole blood or concentrated platelet preparations may be helpful. Vaginal delivery with avoidance of trauma to maternal soft tissues is the optimal mode of delivery for these patients. In the fourth stage of labor, particular attention must be paid to maintain uterine contraction and avoid hemorrhage due to uterine atony.

---

(1) Peterson, O. H., Jr. and Larson, P., "Thrombocytopenic Purpura in Pregnancy", Obst. and Gynec., 4:454, 1954.



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

ndications: Urinary tract infections caused by gram-negative and some gram-ositive organisms.

ide effects: Mainly mild, transient gastrointestinal disturbances; in ccasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild osinophilia, reversible subjective visual disturbances (overbrightness of ghts, change in visual color perception, difficulty in focusing, decrease in isual acuity and double vision), and reversible photosensitivity reactions. larked overdosage, coupled with certain predisposing factors, has produced rief convulsions in a few patients.

recautions: As with all new drugs, blood and liver function tests are advis-ble during prolonged treatment. **Pending further experience, like most hemotherapeutic agents, this drug should not be given in the first trimester f pregnancy. It must be used cautiously in patients with liver disease or evere impairment of kidney function.** Because photosensitivity reactions have ccurred in a small number of cases, patients should be cautioned to avoid nnecessary exposure to direct sunlight while receiving NegGram, and if a eaction occurs, therapy should be discontinued. The dosage recommended or adults and children should not arbitrarily be doubled unless under the areful supervision of a physician. Bacterial resistance may develop.

/hen testing the urine for glucose in patients receiving NegGram, Clinistix® eagent Strips or Tes-Tape® should be used since other reagents give a alse-positive reaction.

osage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times aily) for one to two weeks. Thereafter, if prolonged treatment is indicated, he dosage may be reduced to two Gm. daily. Children may be given pproximately *25 mg. per pound* of body weight per day, administered in ivided doses. The dosage recommended above for adults and children hould not arbitrarily be doubled unless under the careful supervision of a hysician. Until further experience is gained, infants under 1 month hould not be treated with the drug.

ow supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conve-iently available in bottles of 56 (sufficient for one full week of therapy) and in ottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

eferences: (1) Based on 23 clinical papers, 1512 cases. Bibliography on equest. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: ntimicrobial Agents and Chemotherapy—1964, Ann Arbor, American ociety for Microbiology, 1965, p. 722.

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eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

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* ESPECIALLY VALUABLE IN U.R.I.
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Signemycin 375—high-potency capsules for simpler administration, greater patient economy

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(tetracycline 250 mg. triacetyloleandomycin 125 mg.)

Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

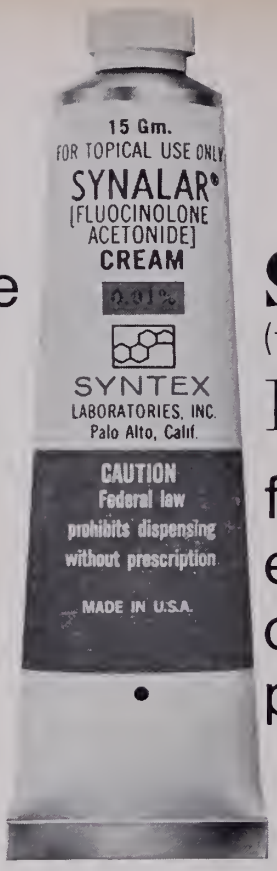
Contraindications: Contraindicated in Individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug. Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.



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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of extensive areas, systemic absorption of the corticosteroid may occur, and suitable precautions should be taken. Occasional patients may show contact sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, or pyodermas have been seen infrequently with the use of this technique. The development of infection requires appropriate antibacterial therapy and discontinuation of the occlusive dressing method. Local atrophy and striae have been reported with protracted occlusive dressing therapy. While lesion relapses can be expected to occur in many psoriatic patients, remissions may persist for several weeks to several months in favorable cases. The patient whose psoriasis is in an active stage, with recent appearance of new lesions, may not be a good candidate and may show early relapse. Some plastic films may be flammable, and due care should be exercised in their use. Similarly, caution should be employed when such films are used on or left near children to avoid the possibility of accidental suffocation. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. **References:** 1. Cahn, M. M., and Levy, E. J.: J New Drugs 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O.: J Irish Med Ass 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Dunseath, W. J. R.: Southern Med J 56:797 (Jul.) 1963.

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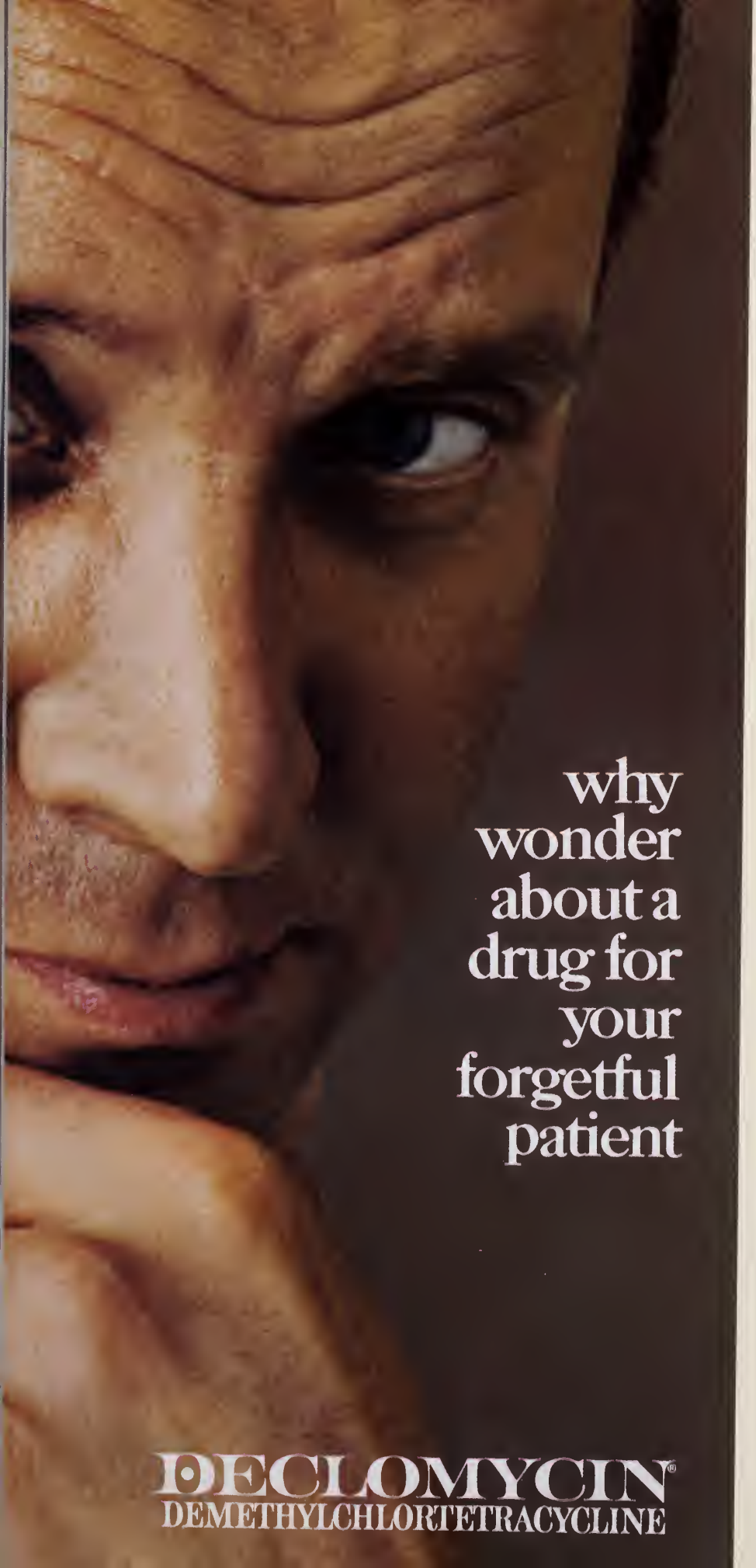
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Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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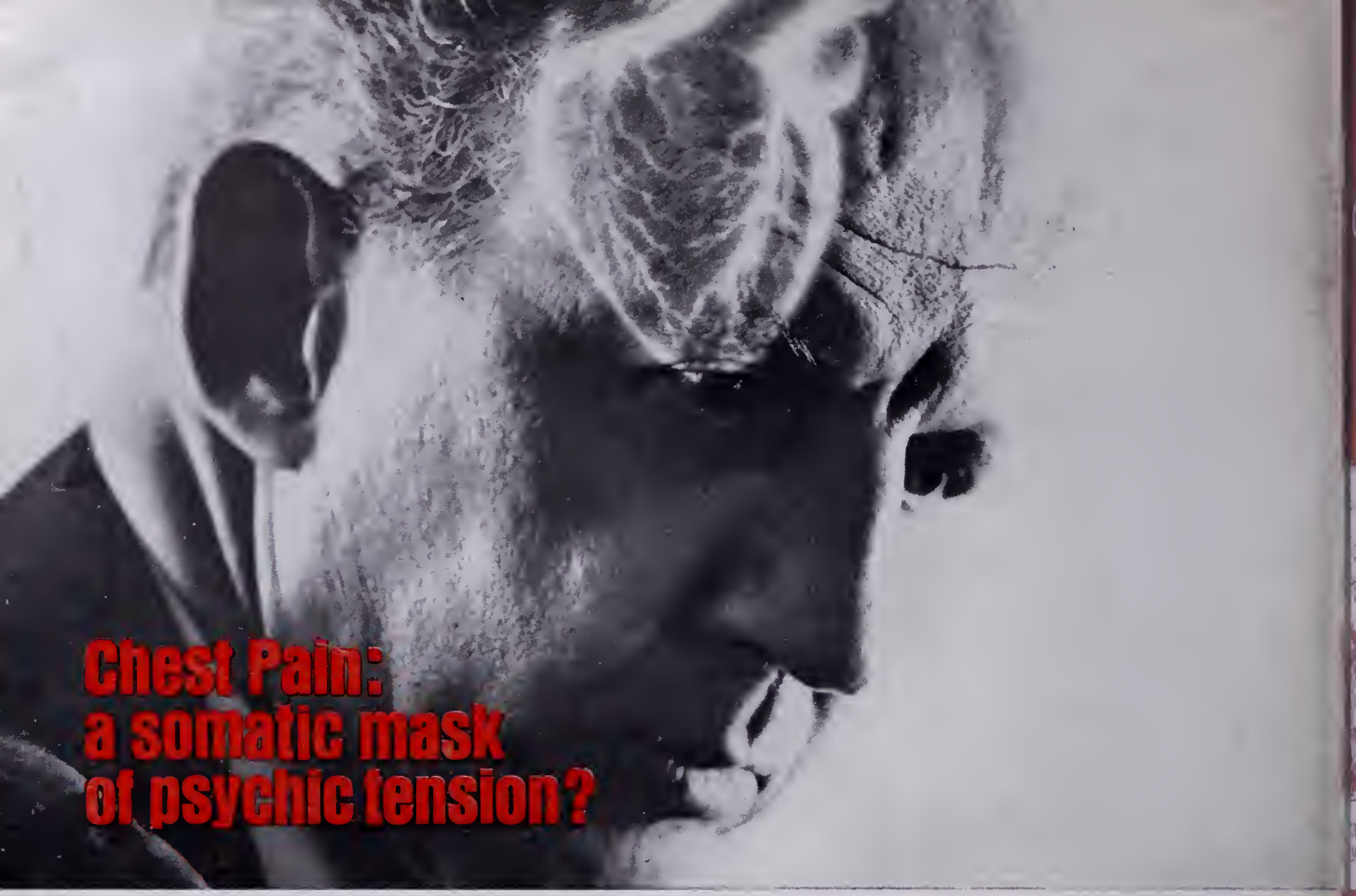
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Valium (diazepam) is generally well tolerated, and usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

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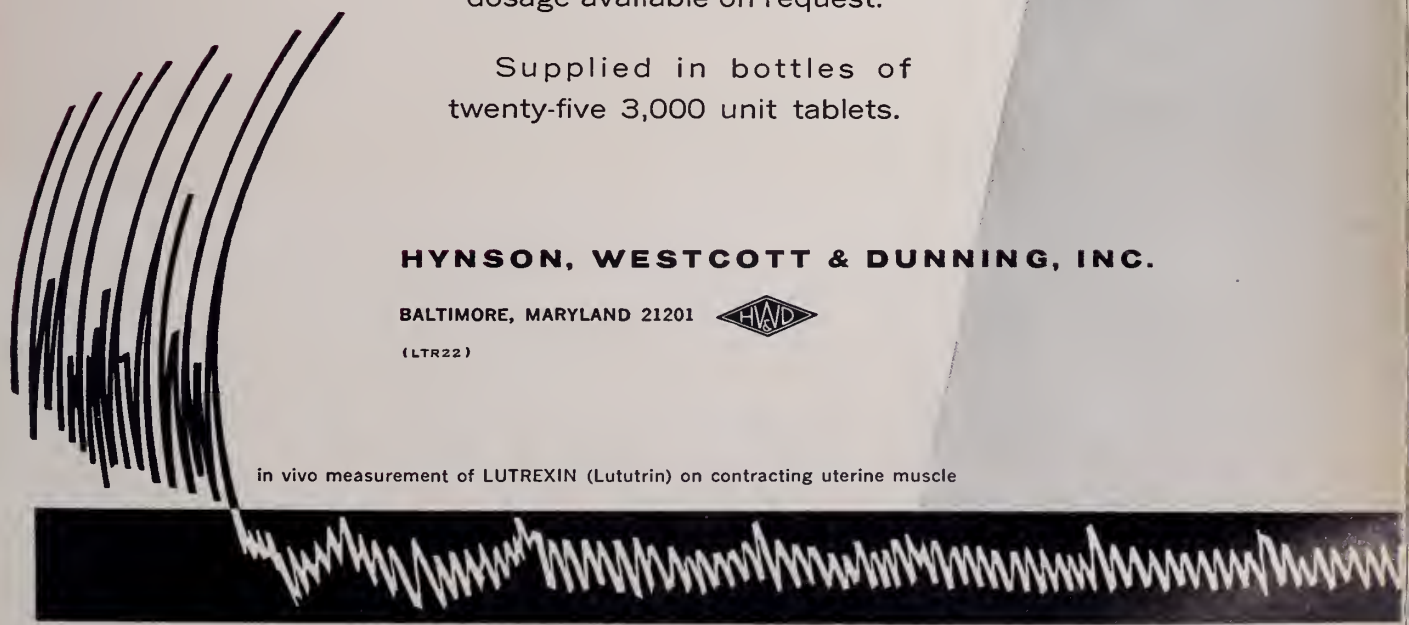
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pyelitis?
urethritis?
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in any case,
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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

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References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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FROM THE PRESIDENT

DURING the past summer the Departments of Health and Economic Security initiated a fee schedule for the recipients of Title XIX under Public Law 89-97 in which physicians in different categories received varied fees according to their classification as specialists or non-specialists.

These departments contended that a fixed fee schedule is necessary for them to budget the various expenses needed to meet the health care of these beneficiaries. In addition to physicians, other vendors such as hospitals, druggists, and dentists must be paid from a fixed allocated sum of money.

A large number of private practice physicians contend it would be more economical for the physician to be paid their usual and customary fee for the services they render rather than the fixed fee announced. To substantiate this it will be necessary that a survey of fees of private physicians in Kentucky be made. The House of Delegates of Kentucky Medical Association approved such a study at the annual meeting in September.

Blue Shield and the Kentucky Department of Health have indicated they are willing to undertake and bear the expense of such a survey. To be accurate this survey will require the cooperation of at least 75% of the private physicians in our state.

A program based on the usual customary and prevailing fee operated by Blue Shield for one large industry in Jefferson County has recently completed its first year. Of about eleven thousand claims, 97.8% were paid without question. It was necessary to adjudicate only one claim.

The physicians have been pleased with the plan, the employees are happy, the employer is gratified and the carrier is satisfied. Where all involved are so content, arguments against such a plan are hard to substantiate.

More and more industries and employers are demanding similar programs and I would urge every physician to cooperate in the survey in hopes that Title XIX could be operated in an equally successful manner.

Robert E. Pennington

Most of my patients with high blood pressure are as old as I am. A lot of them are living on pensions. They're grateful when I can keep prescription costs down.



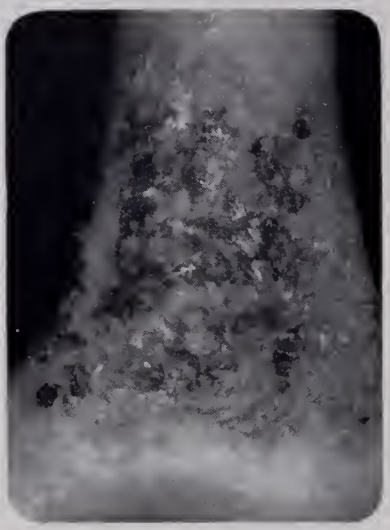
Regroton®

chlorthalidone 50 mg. reserpine 0.25 mg.

1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy



R. R., Age 11—Before treatment—atopic eczema of long standing



After treatment—with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of childhood eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

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Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%

Triamcinolone Acetonide

Also available in foam form and with neomycin.

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e18 6



this part for diarrhea

Kaolin exerts a demulcent action along the gastrointestinal tract and a detoxifying action in the intestines to diminish irritation of the mucosa and lessen hyperperistalsis, nausea and diarrhea.

Pectin exerts its demulcent effect in the entire tract and its detoxifying action primarily in the large bowel to diminish irritation of the mucosa and help restore normal intestinal flora and function.

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Belladonna alkaloids as in Donnatal® relieve hypermotility of smooth muscle in the gastrointestinal tract to help control cramping, nausea, and painful straining. Many clinicians consider the belladonna components of Donnagel® to be medicine's most effective depressants of intestinal motility.[1,2] A preparation containing only kaolin and pectin, on the other hand, has "little or no effect on cramps simply because it does not include an agent with antispasmodic action."[3]

Donnagel® treats the whole diarrhea problem.

Available in new 4-ounce plastic bottle on your prescription or recommendation. Also available: Donnagel®-PG (with paregoric equivalent) and Donnagel® with Neomycin. See product literature before prescribing.

References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., *32*:1227, 1948. 2. Hock, C.W.: Clin. Med., *8*:1932, 1961. 3. Winfield, I.W.: Am. J. Gastroent., *31*:438, 1959.

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A. H. Robins Company, Inc.
Richmond, Virginia 23220



"CLEAR THE TRACT" WITH

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Clear the Respiratory Tract with Robitussin.

Much more than just a slogan, "clear the tract" reflects the dependable antitussive-expectorant action of the three Robitussin formulations. All contain glyceryl guaiacolate, the time-tested expectorant that greatly enhances the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Glyceryl guaiacolate is safe, non-narcotic, and almost universally accepted by patients of all ages.

NOW! THREE ROBITUSSIN FORMULATIONS	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM
EXPECTORANT	●	●	●
DEMULCENT	●	●	●
COUGH SUPPRESSANT		●	●
ANTIHISTAMINE		●	
LONG-ACTING (6-8 hours)			●

FORMULAS

ROBITUSSIN®
in each 5 cc. teaspoonful:

Glyceryl guaiacolate	100 mg.

(Alcohol 3.5%)

ROBITUSSIN® A-C
(exempt narcotic)
in each 5 cc. teaspoonful:

Glyceryl guaiacolate	100 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.

(warning: may be habit forming)
(Alcohol 3.5%)

ROBITUSSIN® -DM
new, non-narcotic
in each 5 cc. teaspoonful:

Glyceryl guaiacolate	100 mg.
Dextromethorphan hydrobromide	15 mg.

Robitussin and Robitussin-DM are available at pharmacies everywhere on your prescription or recommendation.

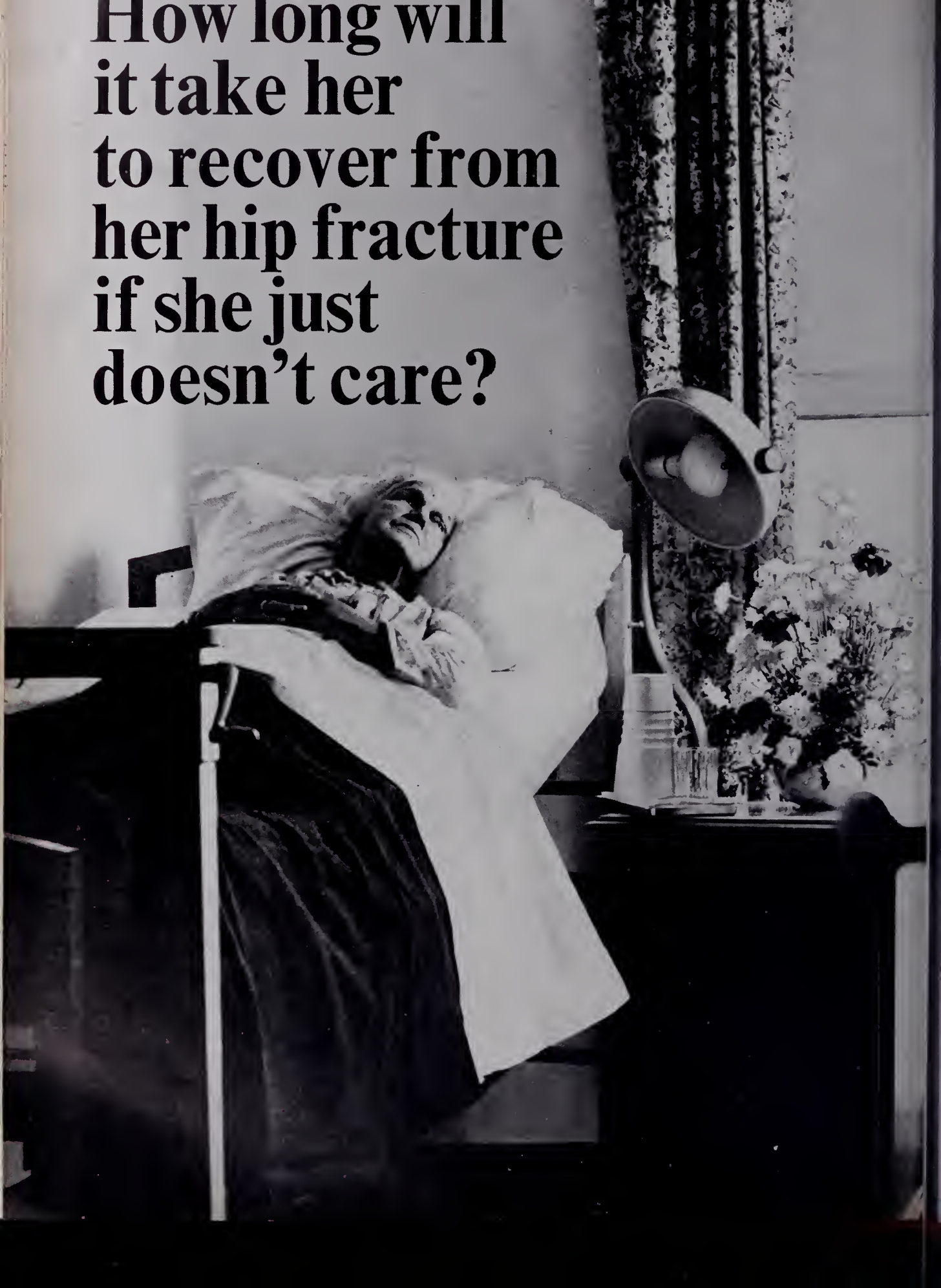
A. H. Robins Company, Inc. Richmond, Va.

OUR PHOTO:
Engine No. 89 of the Monadnock, Steamtown & Northern Railway pulls a trainload of steam enthusiasts through the New England countryside between Bellows Falls and Chester, Vermont.

A·H·ROBINS

ONE OF THE ROBITUSSIN® FORMULAS

How long will it take her to recover from her hip fracture if she just doesn't care?



Does she really care? Is she alert, encouraged, positive and optimistic about getting completely well soon?

Or has she given in to the demoralizing impact of confinement, disability and dependency?

When functional fatigue complicates convalescence, Alertonic can help...

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that can often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Alertonic®

Available Only On Prescription

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Merrell

THE WM. S. MERRELL COMPANY
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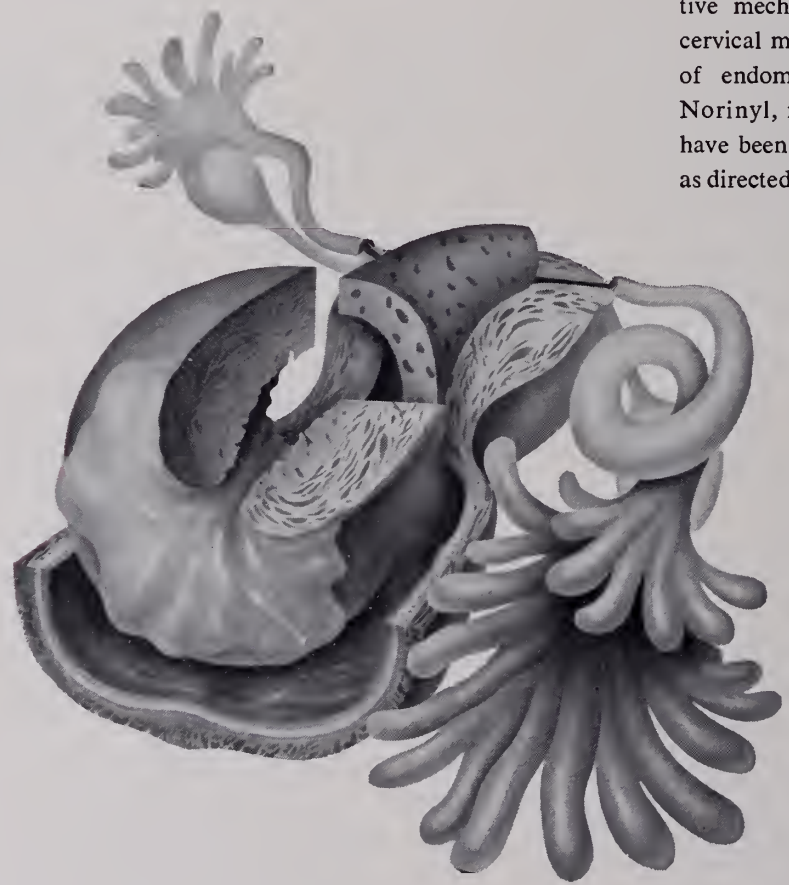
Norinyl tablets
(norethindrone 2 mg. ē mestranol 0.1 mg.)

for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation



no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

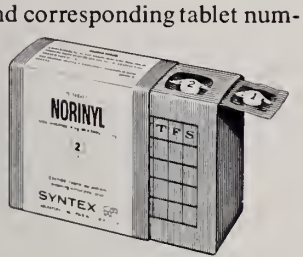
plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from
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Norinyl® tablets
(norethindrone 2 mg ē mestranol 0.1 mg)
for multiple contraceptive action

vignettes of angina pectoris—
no. 1 in a series:

angina and the surgeon

John Hunter—
British surgeon (1728-1793)

angina of anger

"My life is in the hands of any rascal who chooses to annoy and tease me."[1] So said the great British surgeon and anatomist, John Hunter, realizing that he could not control the anger which precipitated frequent and severe attacks of angina pectoris. According to Mettler: "His statement was no exaggeration. On October 16, 1793, he attended a meeting of the St. George's hospital staff, and, while defending the interests of several students, he was contradicted and thoroughly antagonized. The pains of angina commenced, he started toward another room, gained it, and fell dying into the arms of a physician."[2]

Why Edward Jenner withheld his paper on angina In 1777, at an earlier stage of the condition, Hunter's angina alarmed a favorite pupil, Edward Jenner, who wrote to Dr. Heberden that he feared his teacher was "affected with symptoms of the Angina Pectoris."[3] So concerned was Jenner about his former teacher's emotion-related condition that he deliberately cancelled publication of a paper on angina pectoris, fearing that Hunter would read it, and have "his fears excited by its truly formidable nature."[4]

Severity of angina described Hunter's brother-in-law, Dr. Everard Home, who witnessed h death and performed an autopsy gave this account of the later sta s of the condition:

"...the pain became excruciatin at the apex of the heart; the thro t was so sore as not to allow of an attempt to swallow anything an the left arm could not bear to be touched....

"The affections above described were, in the beginning, readily brought on by exercise... but th at last seized him when lying in bed, and in his sleep...."[5]



18th century ancestor of the modern coronary candidate Surgeon, anatomist, pathologist physiologist, geologist, and teac Hunter had a passion for resear which led him to disregard his practice, his health and even th

aw. When the Irish giant O'Brien earned that Hunter desired his keleton for a museum, he willed hat his body be sunk at sea in a ead coffin. But Hunter was not to e denied. According to Major, he '... bribed the watchers and finally btained the body at a cost of 500 ounds although he had to borrow he money to pay the men."[3]
n 1767, he experimentally inocuated himself with gonorrhea and yphilis, treated himself with nercury for three years, and was pparently cured.[5] Hunter had eelings of inadequacy about his ducation and speaking ability, ut this did not prevent him from eing hard driving and abrupt ith his colleagues. His competiiveness with his physician older rother was also well known, and nded in complete estrangement etween the two men.[2,3] Today, the ersonality traits seen in John Hunter are recognized to be impornt predisposing factors in the develpment of coronary artery disease—ften manifested as angina pectoris. ccording to Friedman and Rosenan,[6] in a group of men whose beavior was characterized by intense mbition and competitive drive, greater than average incidence angina pectoris was among those normal conditions noted.

eferences: 1. Paget, S., cited by Mettler, . A.: History of Medicine, Philadelphia, he Blakiston Company, 1947, p. 85. Mettler, C. A.: *Op. cit.*, pp. 84-85. Major, R. H.: A History of Medicine, ringfield, Ill., Charles C Thomas, 1954, l. 2, pp. 601-607. 4. Baron, J., cited by ajor, R. H.: *Op. cit.*, p. 607. 5. Major, R. .: Classic Descriptions of Disease, ed. 3, ringfield, Ill., Charles C Thomas, 1955, 423. 6. Friedman, M., and Rosenman, . H.: J.A.M.A. *169*:1286, 1959.

in the modern management of angina pectoris

Peritrate® SA

Sustained Action (pentaerythritol tetranitrate) 80 mg.

Each double-layer, biconvex, dark green/light green tablet of Peritrate SA Sustained Action contains:
pentaerythritol tetranitrate . . . . . 80 mg.
(20 mg. in immediate release layer and 60 mg. in sustained release base)

Peritrate (pentaerythritol tetranitrate) is a nitric acid ester of a tetrahydric alcohol (pentaerythritol).

Actions: The exact cause of angina pectoris (that is, the pain associated with coronary artery disease) remains obscure, despite the numerous and often conflicting hypotheses concerning its pathophysiology. Therapy at the present time, therefore, remains essentially empiric. Customarily, clinical improvement has been measured by: reduction in (1) number, intensity and duration of angina pectoris attacks and (2) necessity for glyceryl trinitrate intake for prevention or relief of anginal attacks.

Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. has been reported in clinical usage to reduce in number and severity the incidence of angina pectoris attacks, with concomitant reduction in glyceryl trinitrate intake.

In the evaluation of Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. in angina pectoris, clinical improvement has been customarily measured subjectively by reduction in number and severity of attacks and necessity for glyceryl trinitrate intake for prevention or abortion of anginal attacks. Individual patterns of angina pectoris differ widely as does the symptomatic response to antianginal agents such as pentaerythritol tetranitrate. The published literature contains both favorable and unfavorable clinical reports. In conjunction with total management of the patient with angina pectoris, Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. have been accepted as safe for prolonged administration and widely regarded as useful.

Animal pharmacology: In a series of carefully designed studies in pigs, Peritrate (pentaerythritol tetranitrate) was administered for 48 hours before an artificially induced occlusion of a major artery and for seven days thereafter. The pigs were sacrificed at various intervals for periods up to six weeks. The result showed a significantly larger number of survivors in the drug-treated group. Damage to myocardial tissue in the drug-treated survivors was less extensive than in the untreated group. Pigs rather than dogs were used because their coronary artery distribution more closely resembles that of human beings. Studies in dogs subject to oligemic shock through progressive bleeding have demonstrated that Peritrate (pentaerythritol tetranitrate) is vasoactive at the postarteriolar level, producing increased blood flow and better tissue perfusion. These animal experiments cannot be translated to human behavior

Indications: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. is indicated for the relief of angina pectoris (pain associated with coronary artery disease). It is not intended to abort the acute anginal episode but is widely regarded as useful in the prophylactic treatment of angina pectoris.

Contraindications: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. is contraindicated in patients who have a history of sensitivity to the drug.

Warning: Data supporting the use of Peritrate (pentaerythritol tetranitrate) during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

Precautions: Should be used with caution in patients who have glaucoma.

Adverse reactions: Side effects reported to date have been predominantly related to headache (which may require discontinuation of medication) and gastrointestinal distress which are usually transient with continuation of medication.

Dosage: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg., 1 tablet immediately on arising and 1 tablet 12 hours later (on an empty stomach).

Additional dosage forms
Peritrate (pentaerythritol tetranitrate)—10 mg. and 20 mg. tablets with or without phenobarbital.

Peritrate with Phenobarbital SA Sustained Action—80 mg. pentaerythritol tetranitrate and 45 mg. phenobarbital.

(**Warning:** Tablets containing phenobarbital may be habit forming.)

WARNER-CHILCOTT
Morris Plains, N. J.

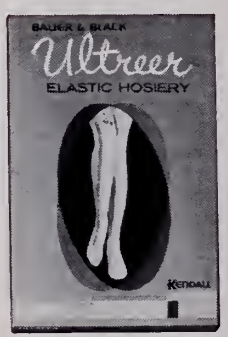
If you can't alarm her into wearing elastic stockings...

charm her with Ultreer™

You see, a woman simply has no defense against Ultreer Elastic Stockings. They look like lovely support stockings. They feel like lovely support stockings. They're that sheer, and shapely and comfortable.

But that's where the similarities end. New Ultreer fits firmly and evenly over the entire leg. Gives true therapeutic compression necessary to relieve varicose veins and other leg disorders. Each pair provides the therapy you prescribe. And at such a low price, a woman can afford two pairs of Ultreer as easily as she can afford one pair of ordinary elastic hosiery.

Ultreer. What a stocking.



KENDALL
BAUER & BLACK SUPPORTS DIVISION



fall 1966

DORSEY Season

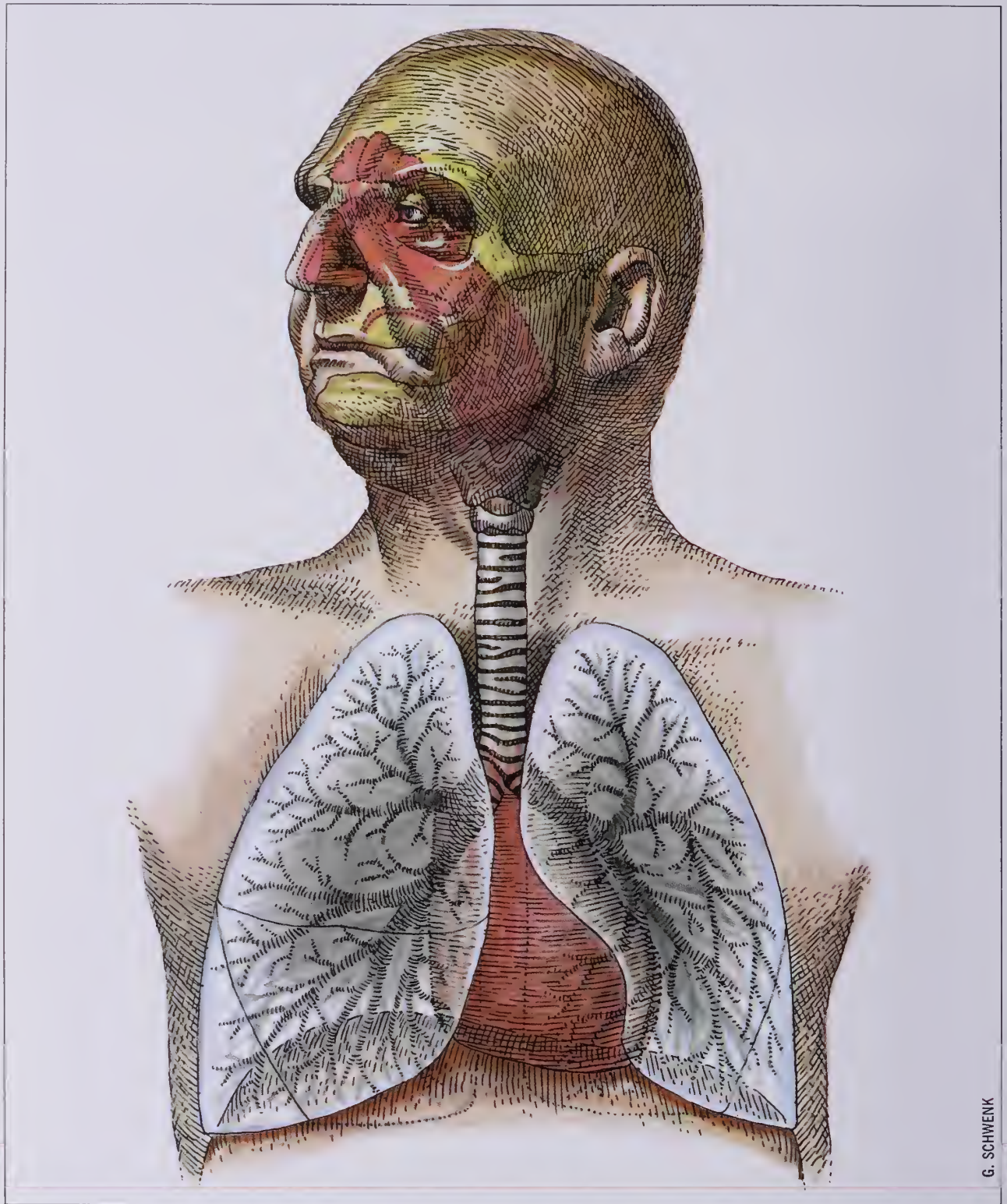
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this issue: the common cold and the aging patient

The common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



G. SCHWENK

Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to broncho-pneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

The anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

it's a
comforting thing
to know



For postnasal drip, clogged ears
and stuffed and runny noses

Triaminic® timed-release tablets

keeps patients comfortable 'round the clock. 24-hour decongestion on just a single tablet dosed morning, mid-afternoon and at bedtime. Patients regain senses and can breathe, smell and taste again.

Triaminic. Isn't that a comforting thing to know?

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.
Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

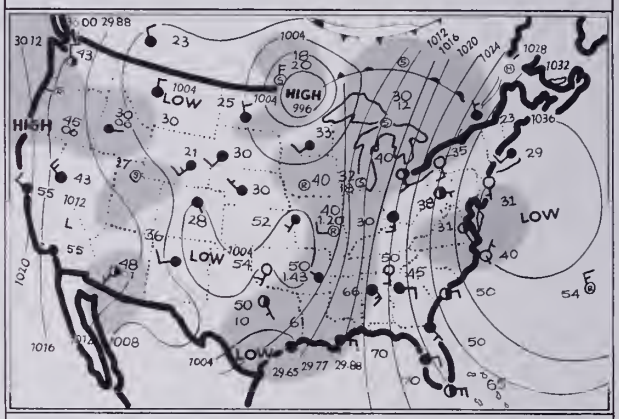
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often realized and not stolen by untimely death.

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Weather Forecast Throughout the Nation



RAIN TURNING TO SNOW, INCREASING WINDS AND DROPPING TEMPERATURES FOLLOWED BY COUGH, CONGESTION AND PAIN

Tussagesic® provides up to 24-hour coverage of the tough cold with a single timed-release tablet dosed morning, midafternoon and at bedtime. Coughs are broken up, runny and stuffed noses are cleared and pain is relieved.

Each Tussagesic® timed-release tablet contains:

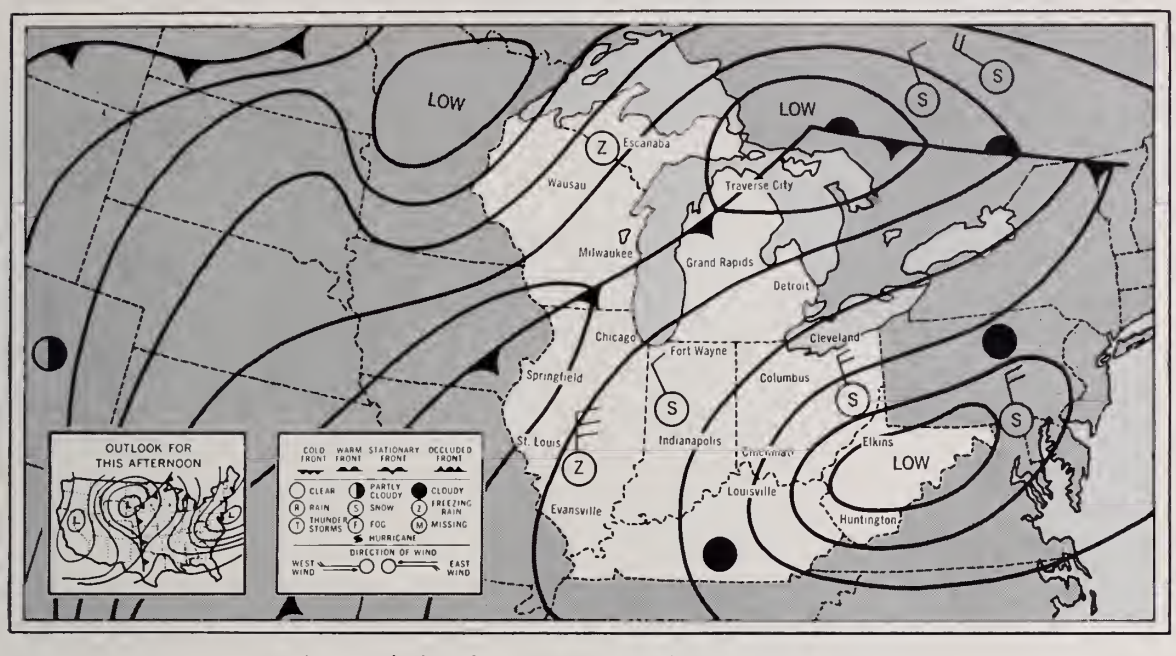
Triaminic® (phenylpropanolamine hydrochloride 25 mg.; pheniramine maleate 12.5 mg.; pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: Patient should not drive a car or operate dangerous machinery if drowsiness occurs. Except under professional care, do not give to patients under 12 yrs. or those who have persistent cough, high fever, heart or thyroid disease, hypertension or diabetes or use for more than 10 days.

(Advertisement)

REGIONAL WEATHER FORECAST

Severe Snow Storms, Strong Winds and Bitter Cold Followed by Cough, Stuffed and Runny Noses and Aches and Pains.



Tussagesic breaks up coughs, quickly clears stuffed and runny noses and relieves aches and pains. Provide coverage of the tough cold for up to 24 hours with just a single timed-release tablet dosed morning, midafternoon and at bedtime.

each

Tussagesic®

timed-release tablet contains:

Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. *Side effects:* Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. *Precautions:* The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES • *a division of The Wander Company* • **LINCOLN, NEBRASKA**

"'Tranquilizer' is not a good word"[1]

"THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there are differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert

References: 1. Simpson, G.M.: Postgrad. Med. *39*:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. *115*:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: *65*:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. *25*:553, 1961. 7. Sainz, A.: Psychosomatics *5*:167, 1964.

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB 'The Priceless Ingredient' of every product is the honor and integrity of its maker



brings peace to the hyperactive colon

CANTIL®
(mepenzolate bromide)

helps restore normal motility and tone

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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A Progress Report in Planning For Emergency Management of Health Resources in Kentucky

Russell E. Teague, M. D., M. P. H.
Commissioner of Health
Commonwealth of Kentucky

In the event of a nuclear attack, the threat of such an attack or any other national emergency which might cause an isolation of the Commonwealth of Kentucky from the national government, the resulting effect upon our economic and governmental system could result in a breakdown of normal supply and communication channels and chaos in law and order. Despite all Federal efforts to prevent such an occurrence, it could happen here. If such were the case, survival would not be possible if the Commonwealth was not prepared to survive for an unknown period of time through its own efforts.

With the foregoing in mind the Commonwealth of Kentucky on December 1, 1964 entered into an agreement prepared by the Executive Office of the President of the United States to provide for the development of a State Emergency Resource Management Plan. In November 1964, the Governor of the Commonwealth appointed a Resources Priorities Board from leaders of government at all levels, and leaders from the private sector for assistance in preparing an emergency plan to aid in our survival should the need arise.

The Plan is designed to provide Kentucky with the ability to generally assess its essential resources in advance of an emergency, determine the specific availability of these resources in the event of a nuclear emergency, or any other emergency that would isolate Kentucky from the National Government.

In developing this Plan consideration has been given to the responsibilities of the Federal government, its Plan and constitutional authority for non-military preparedness and management of resources in an emergency. Compatibility between the Federal and State Plan has been assured.

A Health Task Group Committee was appointed by Russell E. Teague, M. D., Commissioner of Health, to develop the Health Resources Plan. Doctor Teague assigned the Office of Health Mobilization, State Department of Health, with the responsibility of coordinating with the Health Task Group Committee in developing this Plan. Members of the committee represent the Kentucky Medical Association, Kentucky Pharmaceutical Association, Kentucky Nursing Association, Kentucky Dental Association, Kentucky Veterinary Medical Association, Kentucky Hospital Association, University of Kentucky Medical School, University of Louisville Medical School, American Red Cross, and Division Heads within the State Department of Health.

Since survival and recovery in any National emergency are primary objectives the Task Group Committee determined that the State Resource Management Officials must be prepared to assess available health resources, provide for their judicious distribution, and plan for the resupply of critical health items, until such time as Federal direction and control could be established.

Resource Policy and Guidance Regulations outline the means of procurement and distribution of health-end items and services, along with the assignment of Health Manpower and penalties that are imposed for violations of

(Continued on page 1063)

DACTILASE®

Each tablet contains:
Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
Standardized amylolytic enzyme, 15 mg.;
Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

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For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.



GERILID™

Each chewable tablet contains: nicotinic acid (niacin) 75 mg. and aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

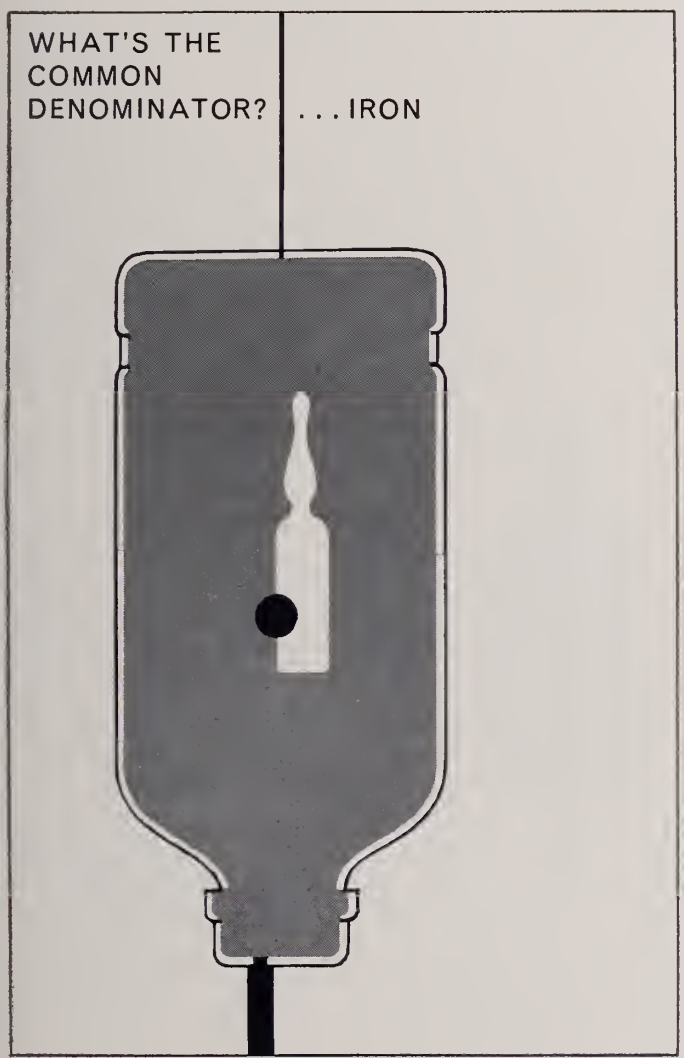
Supplied: Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

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In fact, there's as much iron...250 mg. ...in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron...or orally administered iron proves ineffective or impractical...or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves.



IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses. Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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Is Blue Cross-Blue Shield '65 Really Necessary?

THE coverage of Title 18 of the Medicare law is looked upon as fairly comprehensive basic protection against the costs of health care. Current estimates place the over all coverage at about 65% of the total cost of care. The law recognizes certain facts of human nature which have been borne out by previous health insurance experience, i.e.: The greater the scope of coverage, the greater the utilization of benefits. Deductibles and co-insurance are methods devised by the insurance industry as deterrents to discourage excessive use of health insurance by adding a significant factor of personal financial responsibility on the part of the insured.

Well over half of the beneficiaries of Medicare have previously had some degree of health insurance protection, either through private policies, or coverage from employment, or health welfare and pension funds. Almost universally this coverage would be duplicated in large part by the medicare coverage. Such duplication of benefits has long been deplored in insurance circles as being uneconomic, unnecessary and encouraging higher utilization and higher premium costs. There has been a strong trend toward the inclusion of "antiduplication" provisions in all health insurance policies.

Since the advent of medicare some insurers have continued their coverage, at least for the time being, without change. A far larger group of insurors have discontinued all coverage for the over 65 group. Others, including Blue Cross and Blue Shield have come up with plans which "compliment" the basic medicare coverage by taking care of deductibles and co-insurance and adding additional benefits and extended coverage.

Since the deductible and co-insurance elements are designed as restraints on over-use of the program, it might be assumed that such programs as Blue Cross-Blue Shield 65 will effectively cancel out the value of these restraints. Since it seems inevitable that physicians will be charged with responsibility for any alleged over-use of program benefits, it is important for us to study carefully the ultimate effects of these "complimentary" insurance programs. If the net result is merely to eliminate restraints on over-use of the medicare program the ultimate result will be harmful to the medical profession as well as increasing the over all cost of medical care. Appropriate ways of eleminating such programs from the picture may ultimately deserve serious study.

WILLIAM W. HALL, M.D.

METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*



METAHYDRIN®

(trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

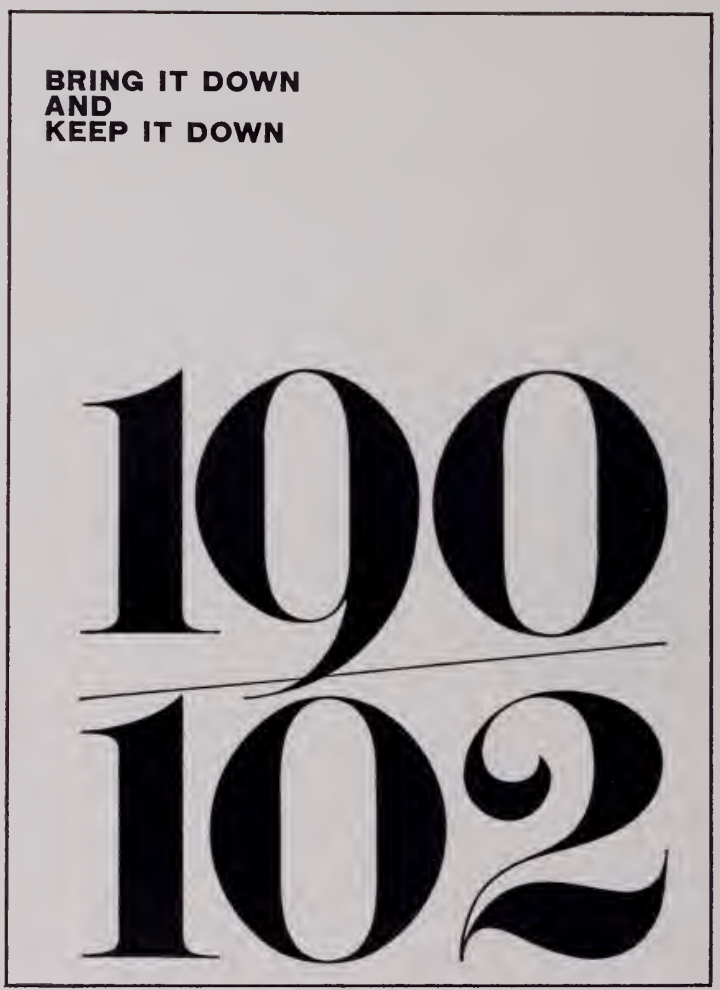
How Supplied: Bottles of 100 and 1000 tablets.

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Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.



METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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When depressed patients say:





"I'm tired all day long"

NORPRAMIN®
(desipramine hydrochloride)
non-sedating · rapid-acting
ANTIDEPRESSANT

helps restore normal patterns of sleep and activity

Norpramin (desipramine hydrochloride) often reverses the signs and symptoms of depression including sleep disturbances feeling of sadness, guilt, anxiety, worthlessness and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, active and less weighed down by their problems.

Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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DISEASES OF THE HEART, Third Edition: Charles K. Friedberg, M.D.; Published by W. B. Saunders Company, Philadelphia, 1966; 1787 Pages; Price, $22.00.

The compilation of a current and comprehensive treatise on even a circumscribed subject in medicine is today a monumental task. For, a single author the assignment seems virtually insurmountable. Yet, for almost two decades, Friedberg's text has overcome the difficulties inherent in encompassing as broad and rapidly changing a field as modern cardiology, to become one of the most useful and widely used in the English language.

In this third edition, the solid foundation of earlier editions is amply refurbished and most of the major advances in patho-physiology and therapeutics of the last decade are included. Bibliographies at the end of each chapter have been up-dated and continue to be one of the more valuable features of the book.

This is the work of a mature cardiologist drawing on many years of clinical and teaching experience. Nonetheless, the presentation of disputed points is objective and representative of current opinion. Friedberg has an excellent facility for correlating physiology and pathology in a relevant and discriminating way. The advantages of single authorship are evident—a consistent plan of organization, clear interconnection of chapters and a unity and consistency of approach to each topic. The reader gains that sense of organic unity so necessary in a detailed work such as this.

Length and detail preclude a critical examination of the entire contents of this book. This reviewer did read carefully those subjects of most immediate interest to him—congestive heart failure, coronary artery diseases, the metabolic aspects of heart disease and bacterial endocarditis. One can occasionally quibble with choice of references, or with such things as enthusiasm for the use of anticoagulants.

But, on the whole, the information is accurate, current, and presented with a well-balanced scientific and clinical approach. There is some repetition in the treatment of congestive heart failure and valvular heart disease largely because of the manner of organizing chapters. This is excusable in a work of such length which few readers will read straight through from cover to cover.

The book is not as readable, concise or sophisticated as Paul Wood's book but it is more complete and equally useful. It can be recommended to all students, and to clinicians no matter how experienced they may be. We have here an excellent reference text presented with wisdom and erudition and seen through the mind of a single author—a rarity and a pleasure not often afforded these days.

E. D. Pellegrino, M.D.

THE HEART—ITS FUNCTION IN HEALTH AND DISEASE: by Arthur Selzer, M.D.; Published by the University of California Press, Berkeley, California, 1966; 279 pages; Price, $5.95.

This book is the cardiac edition of the series *Perspectives in Medicine*, issued to bridge the gap between popular medical books and scientific texts. It is written in scientific language and intended for lay and paramedical persons wishing to read in depth on the subject. It is a short book written in a casual style. All of the medical terms are defined in a glossary.

The author, a professor of cardiology, is a distinguished clinician and researcher. This dual background gives this book more significance since he is able to place many theoretical considerations, such as the role of cholesterol in coronary artery disease, in a practical light.

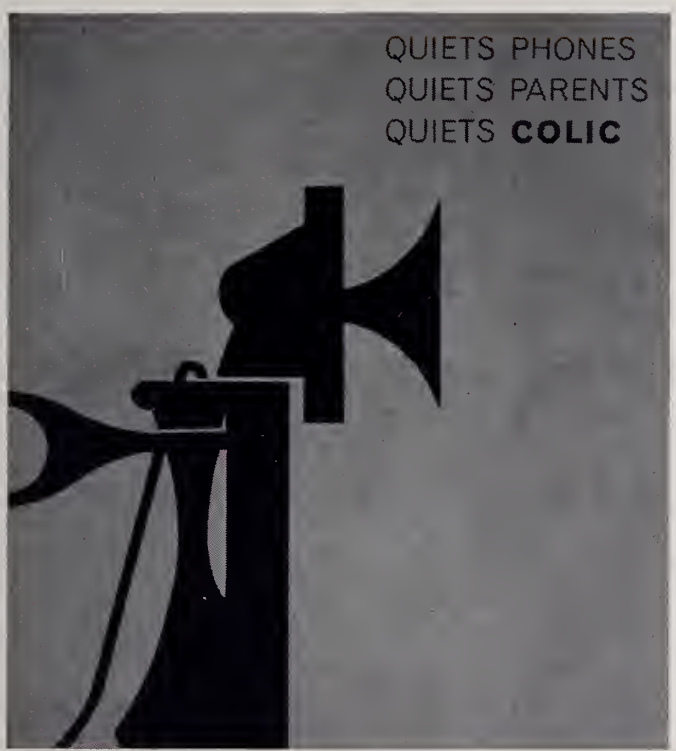
Doctor Selzer begins with a brief survey of the history of cardiology. This chapter highlights the great discoveries beginning with the Greek philosophers, and emphasizes how these individual insights have led to our current state of knowledge. He then describes normal cardiovascular anatomy and physiology, with major emphasis on the heart rather than the peripheral vessels.

The second portion of the essay is devoted to methods of diagnosing and treating the abnormal heart. The author completely neglects the physical examination in discussing the methods of diagnosis and assessment of drug therapy in the failing heart. This is the primary flaw in an otherwise well conceived section.

The final section is a classification and description of the various types of disorders that afflict the heart. The chapter on coronary artery disease is one of the best expositions on this subject the reviewer has ever read. Doctor Selzer clearly puts into perspective the magnitude of this problem. He stresses the multifactoral aspects of this common disorder. The reader is warned not to be caught up in the fads, such as cholesterol, that try to explain all aspects of the disease from a single cause.

Morris M. Weiss, M.D.

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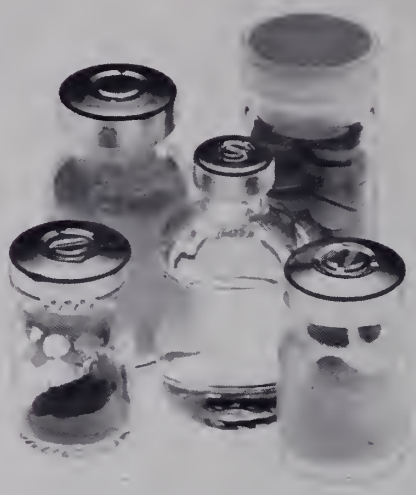
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1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

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Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

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"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

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For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. 2. Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. 3. Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. 4. Berkson, D. M.: Indust. Med. & Surg. 32:371, 1963. 5. Cohen, B. M.: M. Times 91:645, 1963. 6. Lee, R. E., et al.: Am. J. Cardiol. 11:738, 1963. 7. Moyer, J. H.: Am. J. Cardiol. 9:821, 1962. 8. Moser, M.: New York J. Med. 62:1177, 1962. 9. Wood, J. E., and Battey, L. L.: Am. J. Cardiol. 9:675, 1962. 10. Moyer, J. H., and Heider, C.: Am. J. Cardiol. 9:920, 1962. 11. Moser, M., and Macaulay, A. I.: New York State J. Med. 60:2679, 1960. 12. Judson, W. E.: Nebraska M. J. 44:305, 1959. 13. Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. 1:5218, 1961. 14. Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. 15. Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. 10:516, 1962. 16. Reid, W. J.: J. Am. Geriatrics Soc. 13:365, 1965. 17. Feldman, L. H.: North Carolina M. J. 23:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

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The Industrial Hygienist on the Health And Safety Team*

Jerome T. Siedlecki**
Chicago, Ill.

The scope of industrial hygienic activity and its relation to the overall occupational health program is outlined with emphasis on the importance of well-organized programs.

ALL TOO often, management is not aware of the importance and scope of occupational health and the benefits which can be achieved from a well-planned program. Often, too, management does not realize that an occupational health program is largely preventive, with attainable goals defined in terms of better employee health, improved employee and community relationships, increased productivity, and actual savings in dollars and cents.

The Objectives of an Occupational Health Program

To offer guidance in the development and operation of occupational health services, the Council on Occupational Health of the American Medical Association has developed a statement describing the scope, objectives and functions of the program. The original statement was approved by the Board of Trustees and adopted by the House of Delegates of the AMA in 1957, and revised in 1960. The statement lists the objectives as follows:

1. To protect employees against health hazards in their work environment;

2. To facilitate the placement and insure the suitability of individuals according to their physical capacities, mental abilities and emotional make-up in work which they can perform with an acceptable degree of efficiency and without endangering their own health and safety or that of their fellow employees;

3. To assure adequate medical care and rehabilitation of the occupationally ill and injured; and

4. To encourage personal health maintenance.

The AMA statement also lists six essential activities in order to attain the objectives of the occupational health program. The first and most important from the standpoint of prevention is the "maintenance of a healthful work environment" and is described in the statement as follows:

> "This requires that personnel skilled in industrial hygiene perform periodic inspections of the premises, including all facilities used by employees, and evaluate the work environment in order to detect and appraise health hazards, mental as well as physical. Such inspections and ap-

*Presented at Kentucky's Second Governor's Occupational Health Conference, Louisville, Kentucky, March 28, 1966.

**Assistant Director, Department of Occupational Health, American Medical Association.

processes and materials used, provide current information on health aspects of the work environment. This information will serve as the basis for appropriate recommendations to management for preventive and corrective measures."

The other essential activities given in the statement are health examinations, including preplacement and periodic examinations, diagnosis and treatment of occupational injury and disease and emergency treatment of non-occupational injury and illness, immunization programs, medical records, and health education and counseling.

The achievement of the objectives of the occupational health program requires the skills of the disciplines which make up the health and safety team.

While industrial hygiene, medical and safety personnel have their own special tasks, each has the same common objective—to make the work place safe and to keep the worker on the job. The services are inter-related and dependent upon each other.

The safety engineer is concerned with those factors which cause accidental injuries. The industrial hygienist deals with the environmental conditions which cause occupational disease. The physician and nurse also are concerned with the prevention of injuries and diseases as well as repairing the results of sickness or injury and improving the worker's health.

The Role of the Industrial Hygienist

Industrial hygiene is comprised essentially of a union of skills of medical scientists and physical scientists to link the environment and man. Initially, these scientists have been trained as chemists, physicists, engineers, biologists, toxicologists, and physicians. Through experience and graduate study, they have gained knowledge in the other allied disciplines.

Industrial hygienists are employed in industry, insurance companies, universities, research institutions, government — federal, state, or municipal—and membership and trade associations. In industry, some of the larger companies utilize industrial hygiene teams composed of individuals highly skilled in their basic disciplines. Smaller companies depend upon one individual trained in the comprehensive practice of industrial hygiene.

the work of the industrial hygienists are recognition, evaluation, and control. The environment and work processes are studied to recognize the factors having the potential of affecting the health of the worker. Instruments are used to sample the atmosphere and measure these environmental factors. The findings are evaluated to determine the extent of the hazard. Lastly, the exposure is controlled to make the work place safe.

The Environmental Hazards

The environmental factors which may cause occupational diseases and which are of primary concern to the industrial hygienist may be chemical, physical and biological.

The chemical agents in the form of liquids, dusts, fumes, mists, vapors and gases are the largest single group responsible for occupational diseases. Chemical agents may enter the human body by inhalation, ingestion, and skin contact. The chief method is by inhalation. Ingestion may be a factor where toxic agents are being handled, hygiene is poor, and smoking and eating are permitted on the job. Some chemicals enter the body by cutaneous absorption, e.g., tetraethyl lead.

Skin Irritants and Sensitizers

Experience has shown that at least two-thirds of the occupational disease cases are dermatitis. Although most cases are of a mild nature, they may result in a loss of work time as well as a disturbance of employee relations. The cost of treatment and/or compensation of industrial dermatitis would probably be in the neighborhood of 60 per cent of the total cost of occupational disease cases.

Chemicals are used in some operations in almost all plants. Contact with the skin with most of these chemicals for a few minutes or even a few hours of the work day will be harmless if routine hygiene measures are employed. This may range from frequent washing of the hands to a program of daily showers with a change of clean underwear and clean outer protective clothing to reduce the time of contact of chemicals with the body and posibility of absorption through the skin.

Immediate washing of the skin should follow when there has been contact with primary

irritants as strong acids and alkalis, aliphatic and aromatic nitro and amino compounds, or some chlorhydrins which can very rapidly penetrate the skin and cause systemic poisoning or of solvents which, trapped between the skin and clothing, can cause burns.

All solvents can defat the skin in varying degrees to produce dermatitis. Even in spot cleaning of wearing apparel, precautions should be taken to prevent skin contact.

There are some chemical compounds which can react with the chemical components of the skin to produce allergens. No abnormal reaction is noted during the period of sensitization. Then without warning, further skin contact with even a very small quantity of the chemical may lead to a violent skin reaction. Examples are resins of plastics in the uncured states.

Protective clothing, particularly gloves made of a material resistant to the chemical of concern, will assist in preventing skin contact. The best protective gloves are those which are cheap enough to be discarded when contaminated or which can be thoroughly decontaminated.

Dusts Producing Pneumoconioses

Next to dermatitis, the greatest number of occupational diseases occur by the entrance of harmful substances through the respiratory tract. This may be in the form of dust, vapor, mist, or gas.

Experience has shown that the majority of industrial dusts have little effect on health and are of a nuisance type only, contributing toward poor housekeeping. However, many of the inert dusts may produce x-ray shadows in the chest of the worker which can be confused readily with disabling lung conditions.

In order to appraise a dust hazard, it is necessary to know:

1. the composition of the inhaled dust (in order to produce silicosis there must be free silica in the dust);
2. the size of the particles of inhaled dust (only particles of 1-3 microns are deposited directly on the walls of the alveoli);
3. the number of particles of inhaled dust the permissible concentration depends upon the percentage of the toxic component of the dust,
4. the period or length of exposure.

Examples of dust producing pulmonary fibrosis are free silica and asbestos. These dusts usually require years to produce their effects. Examples of dusts that can produce x-ray shadows of the lungs but are not disabling are iron oxide, barium oxide or tin oxide.

Metallic Dust and Fumes

Dust and fumes of many metals and their compounds that are inhaled into the lungs are completely absorbed by the blood system to cause systemic poisoning. Such toxic metals as lead, mercury, chromium, cadmium, and beryllium are used in numerous operations in many industries. Lead is used in printing plants. Lead compounds can be a source of exposure in the petroleum industry. Unless controlled, spraying of paints of high lead content can lead to lead intoxication. Welding or brazing with high temperatures on cadmium plated surfaces can be hazardous. Recently, three welders died after brazing with a silver solder containing cadmium. Chromium electroplating can result in exposure to chromic acid mist or dust of the salts of chromic acid. Chromium compounds also are used in the tanning of leather.

Solvents

Solvents in numerous combinations are used in almost all industrial operations, either in manufacture, maintenance or cleaning. The exact components of a solvent mixture must be known before an appraisal of a possible hazard can be made.

The extent of hazard of a solvent depends upon its volatility, toxicity, and period of exposure. Solvents such as carbon tetrachloride and benzol are very toxic and can produce serious illness unless used under controlled conditions.

Where it is possible, solvents of lesser toxicity should be substituted for the more toxic ones. For example, inhibited methyl chloroform is as effective a cleaning agent as carbon tetrachloride, but does not injure the liver and kidneys. Toluene has solvent properties similar

blood forming organs as does benzol.

Gases

Exposures to excessive concentrations of gases can occur in many industrial operations. Carbon monoxide is the gas most frequently encountered since it is formed whenever organic materials are burned incompletely or in the absence of oxygen. Common sources are furnaces, oil refineries, charcoal ovens and refuse plants. Laundry workers, garage mechanics, furnace tenders, firemen, and cooks, among others, may be exposed to it.

Hydrogen sulfide is formed as a by-product of certain processes. It is found in tanneries, in the production of carbon disulfide, or in the heating of rubber containing sulfur compounds. It also occurs in refinery operations. Examples of other gases are ammonia, formaldehyde, chlorine, hydrogen fluoride, ozone, and sulfur dioxide.

Other Conditions

The biological agents of concern to the industrial hygienist include insects and mites, molds, yeast and fungi; and bacteria and viruses. He should investigate the need and methods of sterilization of such imported animal products as hair, bristles, wool, and hides.

Potential hazards of one or more physical agents may be found in almost all plants. The industrial hygienist must study the extent of exposure to these agents and recommend the necessary control measures. He must investigate the operations in which there are extremes of temperature, humidity, difference in pressure and noise, and those operations involving the use of electromagnetic radiation, such as ultrasonics, ultraviolet light, infrared and lasers, or ionizing radiation such as x-rays and gamma rays.

Engineering Controls

The engineering controls which the industrial hygienist may recommend include local exhaust ventilation and general ventilation. Local exhaust ventilation is used to capture the contaminant at or near its source. This is the best control for dust from grinding operations. General or dilution ventilation is the introduction and removal of sufficient quantration at safe levels.

Another control measure is the substitution of a less harmful material without interference with production operations. The substitution of a petroleum distillate in place of the toxic benzol is an example.

A hazardous operation may be isolated from other plant operations. This usually results in fewer workers being exposed and may simplify control measures. An example is enclosure or isolation of a noisy operation.

A minor change in the process may prevent exposures; for example, the handling of solvents in closed instead of open vessels.

Wet methods may be used for the control of dust. Wet sweeping or vacuum cleaning will keep toxic dust from spreading into the atmosphere.

Respiratory protective equipment should be used only when there is no other practical means of avoiding excessive exposure. Other personal protective equipment may include goggles, shields, gloves, plastic sleeves, aprons, asbestos leggings, or clothing made of aluminized material to protect against radiant heat.

Considerable savings can be attained by proper selection and design of engineering controls. Examples of inadequate or inoperative ventilation systems installed without consultation of a skilled industrial hygienist are numerous. Often, exhaust systems are installed without any consideration being given to heated make-up air. During the cold weather, the building can become "air starved" creating a negative pressure inside the building and causing improper operation of the exhaust hoods and of natural combustion flues and vents.

Roof ventilators are frequently installed when only exhaust hoods will efficiently control the hazard. Proper design of the hoods is essential to prevent air short circuits.

Radiant heat sources should not be controlled by man-cooler fans, but by shielding or providing the worker with vortex tube cooling.

Often, an expensive heating system is installed in a large plant to heat one or two workers when a radiant heater can do the job economically and efficiently without heating large volumes of air and great areas of space.

An exhaust hood is not necessary to control

smoke and fume in quenching operations if Dowtherm is substituted for the oil bath.

A fabric collector will plug up very quickly if installed to control the dust of a muller. A wet collector is preferable.

The industrial hygienist should judiciously select the most effective control measures with full consideration being given to the economics of the production process.

The Present Status of Industrial Hygiene In the U. S.

What is the status of industrial hygiene activity in the United States? There are two professional organizations whose membership comprises the talents and knowledge of those possessing the skills in industrial hygiene. The leading professional organization in the field is the American Industrial Hygiene Association with a membership of 1450. The membership of the American Conference of Governmental Industrial Hygienists is limited to professional personnel in governmental agencies and universities who are engaged in occupational health activities. It has 850 members, 65 of whom work in other countries. Some of its members also belong to the American Industrial Hygiene Association. It is estimated that the total number of skilled industrial hygienists in this country is about 1800. This is the number of specialists trained to recognize, evaluate, and control the health hazards in the occupational environment of 80 million American workers, or one industrial hygienist per 44,000 workers.

The true picture of industrial hygiene activity in the United States is not represented in these figures, since many persons who are not members of the two professional organizations practice some aspects of industrial hygiene. The responsibility for industrial hygiene in small plants has fallen on the other members of the occupational health and safety team. They have done much in bridging the gap in the solution of health problems caused by excessive exposures to hazardous materials, processes, and sources of energy.

The Need of Industrial Hygiene

Awakened management has established occupational health programs which have included industrial hygiene. Occupational diseases in these plants have become a very minor cause of illness absenteeism. These plants are on top of the job.

We should be concerned with plants which do not have adequate occupational health programs and which are not fully aware that the special hazards inevitable in some industries are preventable. It is in these plants that absenteeism caused by occupational disease is high.

The need for industrial hygiene services becomes more evident when we consider the demands of the rapidly changing industrial environment caused by development of new chemicals and complex automated processes. It is estimated that every 20 minutes a new chemical is introduced in industry. These new chemicals and formulations, as well as old chemicals used in new processes and manufacturing procedures, are continually being incorporated in plant operations. These must be investigated thoroughly to determine the existence of potential health hazards.

It is essential that management fully understand the scope and importance of industrial hygiene. The occupational health program of a plant should be tailored by using as guidelines the number of employees involved and the nature of the hazards of the work place. Industrial hygiene, however, should be incorporated in the occupational health program of all plants, small and large, and services provided either by a skilled industrial hygienist or by the industrial physician in cooperation with the plant safety engineer and nurse, and with the assistance of trained industrial hygiene personnel from the insurance company, state health department, or private consultants.

In the absence of an industrial hygienist, the other members of the occupational health and safety team have an obligation at least to recognize a potential environmental health hazard and recommend to management that the services of a skilled industrial hygienist are required. There are many sources of assistance. Insurance carriers, local and state health departments, and outside consultants have been mentioned. Advice, information, and publications can be obtained from the Department of Occupational Health, American Medical Association, Industrial Medical Association, American Academy of Occupational

Medicine, American Industrial Hygiene Association, American Conference of Governmental Industrial Hygienists, Industrial Hygiene Foundation, National Safety Council, Health Physics Society, such trade associations as the American Petroleum Institute, Manufacturing Chemists Association, and American Foundrymen's Society, and the Division of Occupational Health, U. S. Public Health Service. Each of these organizations has developed statements, data sheets and guides on the organization of occupational health programs, on hazards and safe handling of dangerous materials, and on control measures necessary for a safe environment.

There are short courses designed to acquaint the student with the fundamentals of industrial hygiene and to recognize potential health hazards. The National Safety Council annually conducts a one-week course for safety engineers. The Industrial Hygiene Foundation has such training available to its members. The Research and Training Facility, Division of Occupational Health, U. S. Public Health Service in Cincinnati offers two-weeks courses to physicians, industrial hygienists, and others having certain prerequisites. The American Industrial Hygiene Association and the Industrial Medical Association offer very short refresher courses at their annual meetings.

Summary

I have outlined the scope of industrial hygiene activity and its relation to the overall occupational health program. Management, medical, industrial hygiene, nursing and safety engineering personnel must cooperate to monitor man and his environment and make safe the work place. In the industries in which well-organized programs exist, management has rapport with the employees and the community. Without a planned program, both management and the employees suffer in lost time because of increase in illness-absenteeism, in decrease in income, and in lowered morale.

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Diagnosis and Treatment of Occult Carcinoma Of the Breast

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Metastatic carcinoma of the breast without a demonstrable primary lesion requires a somewhat different approach in its diagnosis, prior to definitive treatment.

OCCULT carcinoma of the breast is a rare type of carcinoma or should we say it is carcinoma of the breast with an unusual behavior pattern, as related to the usual pattern of carcinoma of the breast.

This condition came to my attention in November, 1960. At this time a 48-year-old white female presented herself with a chief complaint of a nontender mass in the right axilla. The patient stated that the mass had gradually enlarged. Review of systems was essentially negative. Physical examination revealed a firm mass approximately 8 1/2 centimeters in diameter in the right axilla. The mass was non-tender, smooth in outline, and fixed to the surrounding tissues. Examination of the head and neck were essentially negative. Examination of both breasts revealed no masses. The remainder of the physical examination was essentially negative. The patient was taken to surgery and the mass was excised.

Grossly this appeared to be consistent with a carcinoma. The microscopic pathology report which followed revealed metastatic adenocarcinoma of the mucoid type, which, it was felt, most likely arose from a primary carcinoma in the breast. Following the pathology report physical examination was reviewed. Several other members of the staff were asked to examine the patient's breasts. No evidence of lesion could be found. X-rays of the nasal sinuses, chest, long bones, upper and lower GI series, intravenous pyelogram, and sigmoidoscopic examination were all negative. Dr. Rudolf Noer, in personal communication, at this time suggested that this was an occult carcinoma of the breast and a radical mastectomy on the same side would be the treatment of choice. The patient was returned to surgery the following day, and a radical mastectomy was carried out. Upon examination of the specimen no other positive nodes were found, but a small, firm, retracted area in the lower inner quadrant of the breast was noted. Microscopically this mass was consistent with an infiltrating duct carcinoma of the breast. This patient has made an uneventful recovery and is living and well without evidence of metastasis as of January, 1966.

Occult carcinoma of the breast may be defined as the presence of metastatic disease, most commonly in the axilla without a palpable or demonstrable lesion in the breast. Metastasis of carcinoma from the breast to the axillary nodes without further evidence of disease has been recognized for many years. Dr. William Halstead described two cases in 1907. Dr. Halstead stated, "I have twice seen extensive carcinomatous involvement of the axillary nodes due to mammary cancer, which later in neither instance became demonstrable over a certain period of time, after the axillary glands had obtained conspicuous dimension. In each case, the axillary tumor had been removed, in one of them, the year before, and in the other, perhaps two years prior to my first examination, which, though made in a most careful manner, failed to find the slightest evidence of cancer in either breast. In the course of a few months thereafter, mammary disease manifested itself in both patients." Dr. Halstead later described a third patient operated on for enlarged axillary nodes, who returned two and a half years later because of recurrence in the axilla. Only at this time was

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growth is by no means an indication of its recent origin, and concludes from experience that some mammary cancer metastasizes long before it becomes evident. He cites three cases in which enlarged nodes were removed months before the primary was noted. As early as 1909, Cameron recommended the removal of the breast when malignant axillary nodes were found, if no tumor could be detected in the breast and all other possible sites of a primary carcinoma had been ruled out. The correctness of his thinking was reaffirmed by Jackson in 1948. Jackson presented a case in which the primary tumor had not become evident until three years and four months after positive axillary nodes were removed. Kloph presented a case in 1950, in which the positive axillary nodes were found approximately forty-eight months before the primary tumor. Fitts and Horn presented fifteen cases in which the breast was removed without evidence of a palpable tumor, the initial signs being as follows: Enlarged axillary nodes, four cases; dermatitis of the nipples, four cases; edema of the skin, one case; retraction of the skin, one case; distant metastasis, two cases, one being to the orbit and the other to the liver.

The incidence of occult carcinoma of the breast found by the Mayo Clinic in reviewing some 5,451 cases of carcinoma of the breast was 25 cases, or 5/10 of one percent. From a search of the literature covering some 40 cases, it is apparent that the size of the primary lesion is by no means an indication of its recent origin, nor is it a factor in distant metastasis. Most tumors classified as occult carcinoma of the breast are apparently very slow-growing lesions.

Having reviewed the literature, I believe the following procedure should be followed in the management of this lesion. Following positive node biopsy, if no lesion can be palpated in the breast or discovered upon physical examination, one should do roentgenogram of the chest and sinuses, upper and lower GI series, intravenous pyelogram, sigmoidoscopic examination, radical mastectomy on the same side as the positive axillary nodes should be done. In some 40 cases in which this technique had been followed, careful examination of the removed specimen has been done and the lesion has been found in approximately 98% of the cases.

At this time I would like to discuss mammography in these cases. The earliest report of the value of X-ray diagnosis in the location of non-palpable primary carcinoma of the breast was by Gresham, Cohen and others in the Archives of Surgery in 1955. They presented a series of five cases in which the primary tumor was not palpable but was outlined by mammography. Dr. Robert Egan at the M.D. Anderson Hospital has been largely responsible for the further development of mammography. This technique has been developed to its present degree of efficiency only in the past five years. According to a survey of the most recent literature, diagnosis by mammography is 80% accurate in the hands of radiologists with special training and a good deal of experience in this particular field. Most likely some of these earlier lesions could have been demonstrated by mammography.

In reviewing the literature on occult carcinoma in this series of some 40 cases, it was noted that the five year cure rate was approximately 75%, which is markedly better than in demonstrable carcinoma of the breast with axillary metastasis, in which the cure rate runs from 20 to 45%. The probable reason for this is that the primary lesion in occult carcinoma of the breast is very slow-growing.

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Frequency of Abnormal AC/A Ratio in Commitant Esotropias

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The object of this study was to determine the incidence of abnormal AC/A ratio in children with commitant esotropias and to establish what types could be candidates for miotic therapy.

Introduction

In 1949 S. V. Abraham reported in the American Journal of Ophthalmology the use of miotics in the treatment of convergence strabismus.[1-2]

It was difficult to evaluate this type of therapy due to the short span of the effects of pilocarpine on a ciliary muscle but since the long acting miotics, such as Floropryl and more recently, phospholine iodide have become available, a better understanding and evaluation of miotics in the treatment of certain types of commitant esotropia is now possible and they are the treatment of choice in many cases.

It was with this in mind that it was decided to review a number of cases of esotropia to see if it could be determined what patients would be likely candidates for miotic therapy.

Pathophysiology

In a discussion of accommodative esotropia, a short review of the patho physiology of accommodative esotropia is in order.

When the gaze is shifted from far to near, several integrated mechanisms act. These are the convergence reflex, the accommodative reflex and the pupillary reflex. In normal individuals there is a constant ratio between accommodation and convergence, so that for one diopter of accommodation, there is one meter angle of convergence, for three diopters of accommodation there are three meter angles of convergence, and so on. This ratio of 1:1 is the normal A/A ratio and it is fundamental to emmetropes, hyperopes and myopes. In a hyperopic individual who must accommodate to overcome his refractive error, the situation is distorted in that with more accommodation demanded, more convergence is automatically initiated. In a myopic person, whose accommodation is called upon to a less extent, less convergence is automatically initiated. This violation of the normal A/C pattern would automatically produce esotropia in every hyperopic person were it not for the saving mechanism of the fusional vergence reflex.

In a patient with accommodative esotropia, the fusional vergence reflex is absent or severely underdeveloped. His AC/A ratio is "frozen". No adjustment, or an inadequate amount of adjustment is available, so when he accommodates to overcome his refractive error, his convergence is excessive and uncontrolled and an esotropia results. This is the behavior pattern of the so-called accommodative esotropia with normal AC/A ratio and is secondary to relatively large amounts of hyperopia being present. A second form of accommodative esotropia exists, known as the *abnormal* type. It is felt to be due to either an abnormal innervational pattern between accommodation and convergence wherein normal amounts of accommodation stimulation results in abnormally large amounts of convergence or accommodation which is defective in some manner, with excessive stimulation of the defective accommodative mechansim in an effort to make it work resulting in excessive convergence. The latter view is perhaps the more reasonable one. Here, there is a negligible plus refractive error, or even a small minus one and no significant esotropia exists at far gaze, but a prominent amount shows at near.

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one form of the two, but both forms may coexist. The criteria used for determining whether a child had a normal or abnormal AC/A ratio was the measurement of the deviation with his full hyperopic correction at 20 feet, fixing on an accommodative target and the measurements for near with full correction, also fixing on an accommodative target. If the deviation for near was 10 diopters or more, this was considered to be an abnormal AC/A ratio, together with the fact that when +3.00 spheres were added to the correction, the measurements for near were greatly reduced. Also, as a diagnostic trial,[3] phospholine was used for a period of 10 days and the deviation was then measured for near under the influence of the miotic and if the deviation was greatly improved above that found on the original examination, this was considered an abnormal AC/A ratio.

Another clue may be found when the patient is first seen if he is measured with prism and cover for distance and near, then refracted and atropine used for three days. After three days the child returns and a retinoscopy is done. In many instances the parents will say the turning in of the eyes has improved with the atropine or they have become worse. In the latter instance, it is interesting that most of these cases will prove to have an abnormal AC/A ratio and when the retinoscopy is done a very small hyperopic correction is found, whereas the child whose esotropia seems to be improved by atropine, will have a very high hyperopic correction.

In this review all of the cases of horizontal deviation with a vertical or AV component were eliminated. A number of cases in which the records were not complete were not used. Approximately 200 case records of accommodative esotropia were studied. They were devided into two categories.[4]

1. All cases in which the deviation appeared at birth or the first 8 months of life were considered conginital. The average onset in this group was 6 months of age.
2. Those whose deviation appeared after 1 year were designated as the acquired group. The average age of onset in this group was 2-1/2 years.

In the first category or congenital group 80% had a normal AC/A ratio.

There was a significant difference between the percentage of patients with congenital and acquired esotropia having abnormal AC/A ratios. It appeared in only 20% in the congenital group but increased to 55% in the acquired group. Regardless of whether the patient in the acquired group had a normal or abnormal AC/A ratio, the average age of onset in this group was 2-1/2 years of age.

The Relationship of The Amount of Hypermetropia in Patients with Normal and Abnormal AC/A Ratios

The amount of hypermetropia in congenital esotropia was similar, regardless of whether the patient had a normal or abnormal AC ratio. The average was 1-3 diopters. Among the patients with acquired esotropia, there was an appreciable increase in the hyperopic average, to a range of 4-8 diopters. The patients with acquired esotropia with an abnormal AC/A ratio tended to have the same amount of hypermetropia as patients with congenital esotropia.

The study of the relationship of the AC/A ratio and commitant esotropia brings to focus the fact that the type of abnormal AC/A ratio having excessive accommodation/convergence associated with each diopter of accommodation should be considered as important as the amount of hypermetropia as an etiological factor in the acquired esotropia. This is illustrated by the fact that the average of 2-1/2 diopters of hypermetropia in patients with acquired esotropia with abnormal AC/A ratio is similar to the average amount of hypermetropia in normal children of the same age that do not have strabismus. Therefore, it must be assumed that some other factor must play a part in the etiology. Since 55% of the patients with acquired esotropia had abnormal AC/A ratios, in contrast with only 20% of the congenital group, this relationship between the abnormal AC/A ratio must exist. Those who had normal AC/A ratios with an average of 4-8 diopers of hypermetropia comprised only about 45% of the acquired esotropias.

The remaining 55% were those with abnormal AC/A ratios having an average of about 2-1/2 diopters of hypermetropia. This

observation suggests that hypermetropia alone accounts for no more of the acquired esotropia than the similar number of cases with abnormal AC/A ratios. Since either hypermetropia or abnormal AC ratios can cause esotropia, many with acquired esotropia have a combination of these two etiological factors. However, it requires a larger amount of hypermetropia with a normal AC/A ratio to produce an esotropia while only a small amount will produce an esotropia when the AC/A ratio is abnormal. The age of onset of the acquired esotropia is approximately the same with either etiological factor. Therefore, it is not the etiological factor that determines the onset of the strabismus but the accommodation response that determines the appearance of the deviation, which may appear anytime from age 1 to school age. It is during this period that the child begins to demand that his accommodative mechanism give him clear images for detail vision.[4]

The reasons for the use of miotics are the facilitation of the accommodation and the lessening of associated convergence and esotropia. This is effected by aiding peripheral accommodation so that less central accommodation innervation is called upon with its accompanying reflex convergence. Pilocarpine acts by direct stimulation of the muscle, whereas Floropryl and Phospholine Iodide act by irreversibly combining with cholinesterase to inactivate it. Thus, in most of these medications, effective ciliary contracture is maintained over a relatively long time by permitting continued acetylcholine presence. Miosis is not a significant factor and does not alter the visual acuity.

This form of therapy has a definite place in the treatment of this type of strabismus. When it works, it is preferable to glasses not only for cosmetic reasons but because it gives more incentive to the development of relative fusional divergence and the fusional vergence reflex and more latitute in its exercise when established.[5] While the effect of long term use still remains to be seen, use for three or four years has not shown any harmful results. With careful selection of cases, excellent results may be expected, especially in children over 6 years of age.

The following are examples of esotropias discussed:

1. Congenital Type Non-Accommodating Esotropia with Normal AC/A Ratio

Onset: Birth to 8 months—average 6 months
Hyperopia—1-3 diopters
Esotropia at distance—60 diopters—With correction—50 diopters
Esotropia for near—60 diopters—With correction—50 diopters
No change with phospholine
These cases usually have crossed fixations. Early surgery is indicated in 80% of the congenital group.

2. Congenital Type Non-Accommodative Accommodative Esotropia Abnormal AC/A Ratio

Onset—6 months Hyperopia 1—3 diopters
Esotropia for distance—30 diopters—With correction—30 diopters
Esotropia for near—60 diopters—With correction for near—45 diopters
With +3.00 add—30 diopters for near
This type is similar to the acquired type, only the history of onset is not the same. Sometimes it is very difficult to determine the exact time of onset of the deviation. They may be considered the same insofar as the treatment. Correct the non-accommodative portion by surgery and treat the accommodative with glasses, miotic and bifocals.

3. Acquired Accommodating Esotropia with Normal AC/C Ratio

Onset—2-3 years of age
Hyperopia—4-6 diopters with variable amblyopia—45%
Measurements—Esotropia without correction 35 diopters ortho or small esophoria
Esotropia for near without correction—35 diopters
With correction—Orthophoric or small esophoria for near
Treatment is full hyperopic correction and occlusion or other methods to combat amblyopia plus orthoptic training when old enough. Gradual reduction of hyoperopic correction. We estimate the acquired type about 45%.

4. Acquired Accommodative Esotropia with Abnormal AC/A Ratio

History onset of deviation 2 years old. Has been wearing glasses since then. She is now 15 years old.
Refraction: R + 5.00 + 2.50 X 90 20/40
L + 4.50 + 2.50 X 90 20/20

Esotropia without correction 30 diopters right esotropia
Esophoria—6-10 diopters
Esotropia for near without correction 45 diopters right esotropia
With correction 35-40 diopters right esotropia for near
+ 3.00 add—6-8 diopters esophoria for near
Fuses house fly and stereo animals with + 3.00 add
RX-Phospholine iodine .125% with 2.5% neo-synephrine and bi-focals

5. Accommodative - Non- Accommodative Type with Normal AC/A Ratio

Onset—1-2-1/2 years
Hyperopia 2-3 diopters
Esotropia without correction 50 diopters Esotropia—30 diopters
Esotropia for near without correction—75 diopters
With correction esotropia for near 45 diopters + 3.00 add 30 diopters esotropia for near
Full correction surgery to correct 30 diopters of esotropia
With + 3.00 add. Postoperative treatment with miotic and bifocals

6. ACQUIRED ESOTROPIA WITH ABNORMAL AC/A RATIO

Onset—1-3 years of age
Refraction—Average 1-3 diopters hyperopia with small astigmatic correction.
Measurements—Orthophoric for distance with correction
Orthophoric for near with + 3.00 add—approximately 55%
Treatment—Phospholine Iodine .125% with 2.5% Neo-synephrine or bifocals

Summary

1. There are two forms of accommodative esotropia, the so-called normal and abnormal AC/A ratio types.

2. They may exist separately or in combination with each other or with a non-accommodative element.

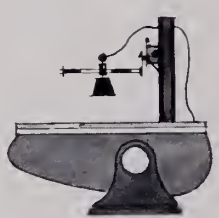
3. The type of patient that is likely to have an esotropia due to an abnormal AC/A ratio is a child from 1 to 3 years of age whose hyperopic correction is less than 3 diopters.

4. The therapy of the abnormal AC/A ratio type consists of miotics and bifocals. The miotic is gradually reduced in frequency and this allows the patient to increase his fusional vergence reflexes. Most patients improve with age as their accommodative reflex becomes better after the age of 5 to 6.

5. Surgery is contraindicated in the treatment of AC/A ratio and is of value only in correcting the non-accommodating portion of the eso deviation.

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Acute Thyroiditis—Report of a Case in a Child

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Although uncommonly seen in children, Acute Thyroiditis should be considered whenever sudden onset of pain and swelling occurs in the region of the thyroid.

Acute thyroiditis is a rare occurrence in the child as attested to by the fact that two recent reviews of thyroid difficulties in children[1,2] fail to mention the problem. Altemeier[3] described a group of ten patients with pyogenic thyroiditis, one of whom was a child of seven years who responded to antibiotics without surgery. In 1954 another case report[4] of recurrent thyroiditis in a child was presented. Each episode seemingly responded to antibiotics, but incision and drainage was finally necessary. Richie[5] and Montgomery[6] were the latest to write of their experiences with suppurative thyroiditis in children.

The following is an additional case report of the non-suppurative form of the disease occurring in a child.

Case Report

G. B., a 3½ year old white male, was seen at home on January 16, 1966, because of fever and swelling in the neck. He had had no preceding sore throat. The mother stated that the child had complained of intense pain in the neck and seemed to have discomfort in the ears.

Physical examination revealed an acutely ill child with a rectal temperature of 105°F. and a pulse of 160/min. He experienced exquisite tenderness when his neck was palpated. His thyroid was three to four times normal size, smooth, and firm. No bruit was heard. His pharynx appeared normal.

Laboratory data showed a hemoglobin of 11.45 gm/100 ml, white blood cell count of 16,250/mm^3 with 64% neutrophiles, 24% lymphocytes, 8% monocytes, and 4% eosinophiles. Sedimentation was 39 mm/hr. Cat-scratch antigen and PPD (intermediate) skin tests were negative. Protein-bound iodine determination was 10.5 mcg%. Thyroid antibodies could not be demonstrated.

The patient was treated with a broad spectrum antibiotic for ten days. Five days after initial examination the only physical finding was a barely palpable but definitely tender right thyroid lobe. At the end of two weeks all evidence of thyroid enlargement had disappeared and the I^{131} uptake at twenty-four hours was 22.7%.

Comment

Acute thyroiditis has been described following measles[7], a cat scratch[8] and mumps[9], and Swann[10] presented evidence of a rise in adeno virus titer in one patient to possibly account for the etiology of acute inflammation of the thyroid.

Thyroiditis usually has a sudden onset with pain, swelling, and discoloration of the skin in the region of the thyroid. Chills and fever are commonly present and the child may complain of hoarseness and dysphagia.

The white blood cell count and sedimentation rate are usually elevated, and the protein-bound iodine determination is generally above normal. I^{131} uptake is decreased perhaps because of increased thyroxin levels in the blood and the inability of the injured gland to trap circulating iodine. Thyroid auto-antibodies may be temporarily present.[11]

Differential diagnosis should include toxic goiter, enlarged cervical nodes, hemorrhage into an adenoma, and carcinoma.

The treatment of acute thyroiditis without suppuration consists of the administration of antibiotics and sometimes cortisone. Williams[12]

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believes that steroids should be given for two to three weeks, then desiccated thyroid for two to three months. If suppuration occurs, drainage should be made through a collar incision.[5] Recovery is generally rapid. Hypothyroidism may be a rare complication.

Summary

A case of acute thyroiditis in a child is presented. Regression of thyroid enlargement occurred with antibiotic therapy. Diagnosis and management of this rare childhood disorder are discussed.

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The Clinical Management Of Volvulus Of The Sigmoid Colon—A Fifteen-Year Experience*

Berel L. Abrams, M.D., and Norton G. Waterman, M.D.
Louisville, Ky.

Tube decompression of sigmoid volvulus is advocated as the primary approach, followed by elective resection when indicated. The operative approach is reserved for the "acute abdomen" or suspected gangrenous bowel.

SIGMOID volvulus is the number one cause of strangulation obstruction of the large bowel in the United States, with a reported mortality of from 14 to 50%.[1,2,3] At the present time it comprises about 3% of all intestinal obstructions and is the second leading cause of colon obstruction in the United States. There is every reason to believe that this condition will become more frequent with the increasing number of the aged as it is more common in the older age group. It is interesting that sigmoid volvulus is a frequent cause of intestinal obstruction in mental hospitals and institutions. In other countries, primarily in Eastern Europe, sigmoid volvulus is a major problem and accounts for 30 to 50% of all intestinal obstructions.

Because of its frequency and the lack of uniformity of treatment, a review of our experience over the past 15 years with sigmoid volvulus has been undertaken in an effort to determine the best solution of this problem.

Pathology and Physiology

To treat intelligently any disease an understanding of the basic pathophysiology is essential. In sigmoid volvulus, the basic pathology is that of a large, redundant sigmoid loop with a narrow base of attachment of the mesosigmoid. Axial torsion is produced by rotation of this loop around its mesenteric axis in either a clockwise or counterclockwise manner, resulting in a twist of 180 degrees or more.

The volvulus, if unrelieved, results in a venous strangulation which is accompanied by distention and a pooling of fluid in this segment. There is engorgement of vessels and frank hemorrhage in the bowel lumen and wall. At the same time, there is degeneration of the bowel wall as a result of anoxia and the proteolytic activity of the bacteria and their toxins. There is transudation of this material from the strangulated segment which may lead to death due to shock from hypovolemia or transperitoneal absorption of the bacterial toxins or both. [4,5,6]

Two basic physiological aberrations exist: a closed-loop, strangulating obstruction of the sigmoid and a simple obstruction of the large bowel proximal to the volvulus. In the high percentage of cases in which the ileocecal valve remains competent, a double closed-loop obstruction results.

Diagnosis

In making the diagnosis, we should recognize that there are two distinct types of sigmoid volvulus:

(1) The acute type, characterized by an explosive onset with nausea, vomiting, abdominal pain and distention occurs mostly in younger patients and progresses rapidly to gangrene.

(2) The subacute, chronic type characteristically occurs in older patients with a history of previous episodes and is associated with abdominal distention, pain, and a more insidious course, but, if unrelieved, progresses to gangrene.

X-ray is a great aid in making the diagnosis. If on the flat and upright film of the abdomen we can see the characteristic large loop (Figure 1) arising out of the pelvis, the diagnosis

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Fig. 1. Classic sigmoid volvulus demonstrating characteristic large loop rising out of the pelvis.



Fig. 2. Barium enema showing obstruction to the flow of barium at the site of the twist with the "bird's beak" or "ace of spades" deformity.
(Both figures from Archives of Surgery, 87: 1033-1039, 1963; reproduced with the permission of the publishers.)

is assured. If there is any question about the films, then a barium enema should be done, which will reveal obstruction to the barium at the site of the twist called a "Bird's Beak" or "Ace of Spades" deformity (Figure 2).

Case Material

This series is comprised of 29 patients with 35 admissions to the Louisville General Hospital and Louisville Veterans Administration Hospital in the 15-year period from 1950 through 1965. The majority were of the subacute, chronic type. There were 24 males and five females in the series, with an average age of 63 years. The most common findings were abdominal distention (75%), pain (50%) and nausea and vomiting (25%). These patients usually had a normal white blood count, low grade fevers, and relatively normal electrolyte patterns.

There were six deaths among the 29 patients, a mortality rate of 21%. There was one death among the four patients with gangrenous bowel, a 25% mortality rate. The number in our series is too small to show the true seriousness of this complication which, in other series, led to a mortality of from 65 to 85%.[1, 7-10]

Among the 35 admissions for primary emergency treatment, there were six deaths (17%) (Table I). In the 11 cases treated with proctoscopic reduction and tube decompression there was one death (9%).

In the operative group there were 24 episodes with five deaths, a 24% mortality. There were two deaths among the 12 operative detorsions (17%).

Table I

PRIMARY EMERGENCY TREATMENT (35 ADMISSIONS)

Treatment	Admissions	Viable Bowel	Nonviable Bowel	Deaths	Per Cent Mortality
Sigmoidoscopic reduction	11	11	0	1	9
Operative detorsion	12	12	0	2	17
Primary resection	2	1	1	1	50
Obstructive resection	9	7	2	2	22
Hartmann's procedure	1	0	1	0	0
Totals	35	31	4	6	17

Nine resections of obstruction were done, with two deaths, a mortality of 22%. Seven of the nine resections were on a viable bowel. These were done earlier in the series, and the practice of resection in the absence of gangrene has been abandoned.

It is important to note that the condition of the patients in the operative group were no different from those in the nonoperative series, with the exception of the three patients with

Table II

DEFINITIVE TREATMENT (21 PATIENTS)

Treatment	Patients	Viable Bowel	Nonviable Bowel	Deaths	Per Cent Mortality
Primary resection	2	1	1	1	50
Obstructive resection	9	8	1	2	22
Hartmann's procedure	1	0	1	0	0
Elective resection	9	9	0	0	0
Totals	21	18	3	3	14.3

gangrenous bowel who presented "acute abdomens." Excluding these patients, the operative mortality was 19%, and must be related to a major operative procedure rather than the condition of the patient per se.

The definitive surgical procedures are listed in Table II. Of 21 patients, three died, for a 14.3% mortality. It is noteworthy that nine elective resections were done with no mortality and one successful Hartmann's procedure was done on gangrenous bowel extending too far down to exteriorize.

Six patients had recurring volvulus, one or more times in the hospital, a 33% recurrence rate. Three of these recurrences followed operative detorsion and three followed nonoperative decompression.

Discussion

We believe that in the acute fulminating case there is no reason for procrastination. These patients present with an acute abdomen and they should be explored as soon as they can be adequately prepared for surgery.

The difference of opinion exists over the emergency care of the patient with the subacute, chronic type of volvulus. There are those who believe that operative detorsion is the treatment of choice and that surgery should be undertaken as soon as the diagnosis is made.

Our belief is that the safest way to handle these cases is by nonoperative reduction by means of the proctoscope and a tube threaded past the twist and sutured or taped to the perianal skin. This should be left in place for at least 24 hours to prevent early recurrence. This method has long been championed by Bruusgaard,[2] who reported 136 successful treatments with four deaths, a 2.9% mortality rate. Drapanas and Stewart[11] record 98 episodes with 82 successful tube decompressions, an 84% success rate with 1.2% mortality. In our own series, we had one death in 11 successful tube decompressions, a 9% mortality rate, and this death was due to a cerebral vascular accident following successful reduction of the volvulus.

The hazard associated with nonoperative reduction must be borne in mind. The proctoscopist must carefully observe the mucosa, and if it appears friable, bloody or discolored, or if one cannot easily guide the well-lubricated rectal tube past the twist, then proctoscopy should be abandoned and the patient prepared for operative decompression. In our series, there was no overlooked gangrenous bowel and no perforations.

If operative management is undertaken, it is wise to place a rectal tube in the rectum preoperatively, then if the bowel is viable, detorsion and guiding of the tube past the twist are all that is done. No operative resection of viable bowel is undertaken, due to the high mortality in our early experience.

Our feeling is further supported by the 25% and 33% mortality rate reported for Los Angeles[1] and Buffalo,[11] respectively, for obstructive resection in viable bowel. The hospital recurrence rate has been quite high, ranging from 40 to 60%.[8,11,12] In our series it was 33%. In view of this high rate of recurrence and the appreciable mortality associated with it, unless age or other medical conditions make the risk prohibitive, a strong argument can be made for elective resection, with its zero mortality rate in our hands to date and the low mortality rate presented by others. This is particularly true in those cases in which it is necessary to perform operative decompression, because of inability to pass the proctoscope, or because dead bowel is suspected. Survival from one episode in no way protects the patient from potentially lethal second or third episodes.

If the colon is decompressed easily by the proctoscope, then one is naturally more hesitant to perform major elective surgery. Again, one must equate the possibility of recurrence with a lethal outcome against both the low risk of elective resection and the life expectancy of the patient. Elective resection can be done between seven and 10 days following the initial episode without any great technical difficulty or increased morbidity or mortality.

In the face of gangrenous bowel, the problem is much more serious. Resection or exteriorization of this segment is mandatory and

and distal loop as a double-barreled colostomy. Care must be taken to avoid unnecessary tension on the bowel in attempting to exteriorize a long enough segment. As pointed out by Bruusgaard[2] and others, the site of the gangrenous twist may be too distal to exteriorize. It will then be necessary to do a Hartmann's procedure, to divide the sigmoid distal to the gangrenous portion, close the distal stump, bring out and excise the proximal gangrenous portion, and create a proximal colostomy. This was done once in our series and the patient survived.

On occasion, in certain select cases, it will be possible to resect the gangrenous bowel and do a primary end-to-end anastomosis. The condition of the patient, the amount of distention and edema of the bowel will all have to be taken into consideration. This was successfully done once in our series.

Conclusion

On the basis of our experience, a plan for the management of sigmoid volvulus has evolved:

1. Nonoperative decompression with the proctoscope and rectal tube followed in most instances by elective resection in about seven to 10 days. For those patients in whom definitive surgery is not indicated, a low fiber diet and wetting agents may be of benefit.

2. If unsuccessful, or if the mucosa appears friable, discolored, or bloody, then immediate laparotomy is indicated.

A. If the bowel is viable, then detorsion is accomplished with a rectal tube passed above the twist and sutured or taped to the anus. No resections are done in the presence of viable bowel. An elective resection is done after seven to 10 days, in most instances.

ly possible.

(2) Hartmann's procedure when the gangrenous segment is too distal to exteriorize.

(3) Primary resection in the rare case in which the general condition of the patient and the bowel permits.

Summary

A brief review of sigmoid volvulus and our experience over the past 15 years has been presented. There were 29 patients with 35 admissions in the series. The mortality rate was 21%.

Nonoperative reduction by means of the proctoscope and rectal tube is advocated as the treatment of choice except when the patient presents as an acute abdomen.

When operative intervention is undertaken, if the bowel is viable, detorsion is all that should be done, followed by an elective resection in most instances. If the bowel is gangrenous then a resection or exteriorization must be done.

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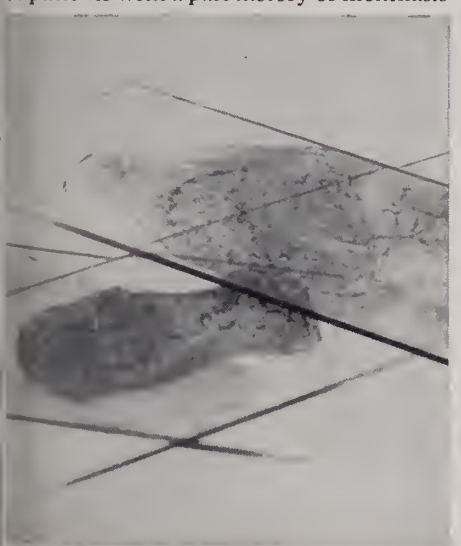
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The Marriage: A Secret Ally For The Physician †

CARL A. WHITAKER, M.D.*

Madison, Wis.

I SHOULD like to subtitle my remarks in such a way as to indicate the possibilities the physician of today has in reopening the old family doctor pattern of being involved with others besides his patient. Psychiatry has for many years been tied to the problem of working with the individual person. We've tried to find more and more of what goes on inside him, why he does what he does, and how we can be useful in straightening out the forces which make him do things which are inappropraite in society, destructive to himself or harmful to those around him. As we have become more confident about how the individual works and somewhat more adept at helping him change himself, we have dared to get involved in his interpersonal operations and gradually the field of family psychotherapy has opened up until there are now well over 400 physicians in this country who are spending part of their time at least in the treatment of families. The author has at this point almost restricted himself to the treatment of families because of his increasing conviction that that's the most economical use of his time. It's more exciting and more creative. In the movement from the treatment of one person to the treatment of a couple and from there to the treatment of the whole family usually involving all the children, several new concepts have emerged. One of the most interesting is the idea that the marriage itself is a third entity, present whenever the physician talks to the husband and wife conjointly. In psychotherapy with the couple it has become more and more obvious that there are three patients and that many times treatment of the relationship between the two or as we title it, treatment of the "third patient," is preliminary to and sometimes all that is needed for the repair of the symptom which originally brought one of the partners in to see a psychiatrist.

> Bill called up because his doctor had referred him for intractable headaches which had been unresponsive to sedatives, tranquilizers, analgesics, etc. The therapist insisted on seeing his wife in the first interview with him and almost immediately the antagonism between the two of them was obvious. She was sweet, helpless and yet in a subtle way undercutting almost everything he said. When it was suggested that there might be some connection between the tension in their marriage and his headaches, he burst out with an explosive assault on his wife's inability to be a person and his intense bitterness about having to endlessly take care of her. It turned out that her passivity was the only way she had learned to handle his aggression and that the two of them were very carefully structuring an impossible marriage based on the normal characteristics of each. The expression of this, the sense in each that the other had a problem and the team decision to talk it out worked nicely. He became less hostile and she less helpless and the marriage omre healthy.

A second concept which has arisen out of family psychotherapy is the extention of an

†*An edited version of a paper presented by Doctor Whitaker at the 1966 KMA Annual Meeting in Louisville, September 21, 1966.*

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old medical concept and really an old philosophical concept that the whole is greater than the sum of the parts, just as the cortex in its relationship to the lower CNS centers is fundamentally an inhibitory organ, a screening device for cutting out rather than for creating or originating. The recent evolution of systems theory into the field of social organization has helped extend the concept that the control of the components of a system is operated by a higher system. That is, the marriage as a system is in control of the functional operation of the individuals in it. The basic function of the marriage is that of inhibition or control. Subsidiary to this is the idea that the power for the marriage and its control comes from the components of the lower order, that is from the two members of the marriage system, or if it's the family, from the parents and children.*

> Joe and Mary had come into therapy with their five children. One of the older ones had been a delinquent and the family was in a chaotic, confused situation. Father had also been unfaithful and things were pretty tense. In the course of the therapeutic process it turned out that father was preventing mother from operating as a person in her social structure and mother was preventing father from doing anything except take care of the kids. It is as though the family had prevented each of these individuals from having an individual emotional enthusiasm for anything outside the system itself. Each was a kind of slave to the marriage.

Working with marriage problems, like the study of other diseases, has uncovered several new concepts. In practice, we expose a pattern of hidden forces as exciting as the discovery of the unconscious many years ago. For example, it's clear to me that both partners in the marriage have equal strength or equal power. Many marriages give one the impression that one partner is strong and the other one is weak. Usually this means that one is expressing the power overtly and the other one is expressing the power in a hidden fashion, like the old story about the king and queen, which we see dramatized in the game of chess. The second surprise is that the immaturity on two sides of a marriage is equal: the two partners are equally childlike. She may seem dependent and childlike and he may seem grownup, practical and down to earth, but after you've worked with them for a while you discover that the childlike wife is the mother person for the man and the so called stable man is really "acting a part." He breaks down and reveals his immaturity at episodic moments of stress. In this sense then the dependency and the maneuvering and the hostility are all equal in each; even though they may be expressed in very different ways. A third equality has emerged, the degree of involvement with each other is also equal. When one partner says she hates, you can be sure that the hatred on the other side is equal. When one person talks about his love and insists there's no love on the other side, you can be sure that this is not a truth, but a misunderstanding on his part and maybe hers, too. Parenthetically, we have discovered some interesting things about marriage as a pattern. The obvious division of marriages into stable and unstable marriages could be reformulated to say that the stable marriages are the ones that are not growing and the unstable ones are the ones that are growing. Thus the unstable marriage is the one I like to see and the stable marriage frightens me just like the stable individual makes me wonder whether some schizophrenia is hiding behind the curtain.

One of the most characteristic subgroups of American-type marriage is what we call the pseudo-therapeutic marriage in which each of the partners is trying to do something about the other, fix him up, change him, modify him. Each one is trying to be the therapist and patient by turn to the other and there develops a deep process of interlocking which makes the marriage very frustrating to both of them.

Out of these experiences with family and couple psychotherapy, I'd like to suggest some experiments that might be pertinent to the practicing physician. These are only ideas on my part, but they may, if you try them, turn out to be worthwhile ones in your practice.

One of them is that you invite the marital partner in for the initial history. We know that patients frequently give an inadequate

**Doctor Len Stein (leaving us at Wisconsin to join Psychiatry at Lexington) is studying the doctor-nurse team. The rules of this social system resemble that of the marriage couple.*

which are important. In psychiatric histories the presence of the marital partner for the first interview is a most valuable way to fix this. At the first interview you are free to make your request that they both be there, suggesting that if there are secret things which they want to talk to you about, they can do that afterwards, and the by-product of this effort may be even better than the product.

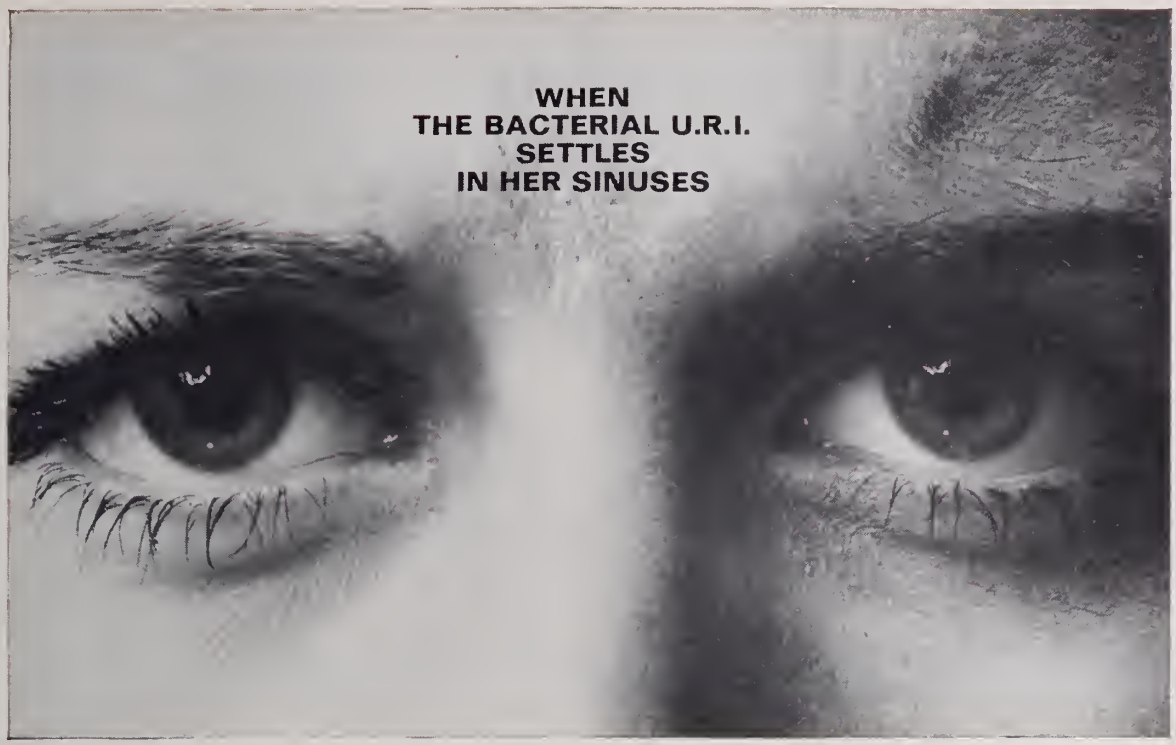
The second experiment which I would suggest is that you have the marital partner in for a report interview. After you have finished your evaluation of a new patient or of a new situation, you invite the marital partner in and report to the two of them together. I'm sure I don't need to tell you that otherwise when the sick one goes home, his understanding and his formulation of what was said is usually grossly distorted. Furthermore, his own misunderstanding may be augmented by the response of his spouse. If they're both there, they get the information more accurately and at least the arguments are part of the marriage battle, not an attack on you.

The third experiment is to invite the marital couple in for a conference at regular intervals with any functional medical problem. There doesn't often seem to be much on the surface when you start but it frequently flips so that you discover new facts, new understandings, and new forces at work within the marriage which are part of the patient's symptom picture. These need not be 50 minute hours. Such a conference can be done in 15 minutes; you have certain things you want to say, they have questions they may want to ask. There is a big gain in prescheduling these. A conference which is preplanned can still take 15 minutes but they may use hours and hours of thinking on the part of each partner and much talk to decide what they want to ask. They will get more out of the conference because of this preplanned conferencing between themselves.

The fourth experiment: Take on a couple divorce, wondering about whether their marriage is valuable, etc. Deliberately set yourself up to try this kind of "psychotherapy" for an experimental couple and see how it works. Pick a young couple, pick a couple who are interesting to you and suggest that they come back and see you every week or every two weeks for a half-hour conference. Parenthetically, I can tell you one of our secrets. I think the difference between a family counselor and a psychotherapist is that the family counselor talks and nobody wants to listen, whereas the psychotherapist frequently just sits and listens, and the patient thereby thinks he's been talking to a wonderful person. Incidentally, you can get past the stage of being boring if you listen "through" what's being said rather than *"to"* it. Listen to it as possible upside down language, listen to it as a way in which they're talking to each other rather than to you or in other ways try to understand more than what appears on the surface.

The fifth experiment and maybe the most interesting one is the possibility that there will be situations in your practice where it would be interesting to see the whole family together. This may sound like a show or an entertainment or some other thing that you don't want to be part of, but try it once, you may find that it will be very valuable. It isn't often that a family gets a chance to present themselves as a group to someone who has a purpose for meeting them, and to whom they can present themselves as a whole. This is for them a very useful experience giving them a new sense of solidarity and a feeling of their own groupness. You may just invite them all in to talk about daddy's headaches or mother's tiredness and you may find valuable contributions made from even the very young children. Not only that but I think it's a good way to relieve some of the stress of the day-by-day beating the physician takes in seeing one patient after another.

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Contraindication—History of hypersensitivity to tetracycline.

Warning—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

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EDITORIALS

Strange Times

THESE are strange times, indeed, especially for those of us in the private practice of medicine.

On the other hand, an almost unprecedented nationwide prosperity exists, in which we as physicians certainly seem to be sharing. We're not sharing is any unusual or disproportinate way, but certainly basic economic need doesn't seem to be a very large area of concern when physicians assess their personal status today. People generally need, want, and increasingly seem to be able to pay for medical care, including physician's services. This is in spite of spiraling hospital costs. Patients also seem to have maintained their high individual regard for their physicians, and are knowledgeable about, and impressed by, the gains that medicine has made in the conquest of disease. Of these gains, there is no doubt; such triumphs as the victory over polio, successful intracardiac surgery, and the first significant but tottering steps along the road toward organ transplant, are commonly acknowledged. Perhaps even more important are the prosaic and common uses of antibiotics to control infection, improved anesthetic techniques to reduce surgical mortality, and new agents to improve the control of diabetes and hypertension. Many more lives are being saved than our professional fathers dreamed of—and yet there are some tigers roaming among the roses in the garden.

For, on the other hand, today's physician is also beset with a revolution in "medical economics". Medicare is upon us, Title XIX is taking its first admittedly inadequate and highly controversial steps, commercial vendors of health insurance are of necessity selling coverages of almost every conceiveable kind, and the confusion mounts. We note that hospital costs per patient day rose during the past year by 9 per cent, to an average of $44.48, according to the American Hospital Association. We note the rising and certainly understandable interest among the nursing profession for wage increases, a factor that certainly will contribute to a continuation of the upward trend. We read that "L.B.J. orders probe of rising medical costs", and small cold chills begin to run up and down our backs. We all know "he who pays the piper, calls the tune", but we had hoped reality wouldn't set in so vigorously, and so soon.

What is our position now? What is our role in the future? Detailed answers to such complex questions cannot be simple. The physician's role in society has been and is being evaluated by research teams of several medical societies —for instance California has recently published an interesting booklet entitled "The Role of Medicine in Society". The Jefferson County Medical Society is also in the midst of such a self-evaluation project, entitled "The Critical Dimension". All of us need to give much thought to these questions, but in spite of all the uncertainties, we need not be disabled by them. For now, as in all uncertain times, we can return to fundamentals for stability and reassurance. We are doctors because we want to help sick people get well; the profession is noble and respected, and has been rewarded well, because that desire came first. Many changes are indeed taking place, but a doctor once is a doctor still, and in the basic act of caring for our patients lies the significance of our past, the stimulus of our present, and the hope for our future.

WALTER HUME, JR., M.D.

Nephrology Comes of Age

THIS year, 1966, marks the founding of the American Society of Nephrology. It is, therefore, the newest of the medical specialties and marks approximately fifteen years of increasing attention and developments in the broad field of nephrology. A working definition of nephrology is—the systematic study of the function and structure of the kidney in health and disease. The definition is necessarily broad since both the basic and clinical sciences are well represented by physiologists, chemists, electron microscopists, immunologists, pathologists, internists and surgeons, all of whom share an interest in the nephron and its disorders. There have been three international congresses of nephrology whose registration figures tell an interesting story:

1960	France	400
1962	Czechoslovakia	900
1966	U.S.A.	2100

A journal, appropriately called NEPHRON, is regularly published and devoted to basic and clinical research.

The strongest impetus to these developments has come about as the result of three distinct circumstances. The first is the availability of methods for studying nephron function. In species as high on the scale as the rat and the dog, it is now possible to sample and analyze glomerular filtrate from individual nephrons. Many of the older concepts of kidney physiology have had to be abandoned or radically revised. Secondly, electron microscopy has provided a powerful tool for studying the structural basis of nephron function. Classical renal pathology, particularly glomerular disease, is being entirely rewritten in the present era. The third major development has been clinical. I refer here to the new methods of treating end-stage renal failure, i.e., dialysis and transplant.

For the practicing physician, there is no need to emphasize the frequency and complexity of the renal problems that confront him. Nephrology centers, usually within the context of a University Medical Center, are increasingly available to provide specialized help. The U.S. Public Health Service currently supports 14 chronic hemodialysis centers in the United States, and several universities have renal transplant programs. The University of Louisville carries on both types of activities, as well as a diagnostic and therapeutic service. The clinical nephrologist of today is usually an internist who has been trained in renal disease in one of the 2-5 year training programs supported by the National Institutes of Health. Residents who want to enter the field may find a number of training opportunities, including the program at Louisville.

The best way to make use of a nephrologist, as with any specialist, is to refer patients for study early in their course. Renal failure comes in all combinations of reversible and irreversible elements which can be quantitatively analyzed and improved to various degrees. The tasks remaining for the future are many, including better methods of detection and prevention of renal disease, improved techniques of transplant, and many others. For the present, the nephrologist is ready and willing to serve his colleagues with the best available methods for diagnosis and therapy.

L. B. BERMAN, M.D.

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RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

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SUPPLIED: 10 ml pressurized aerosol vials complete with measured dose valve and oral nebulizer.

References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.

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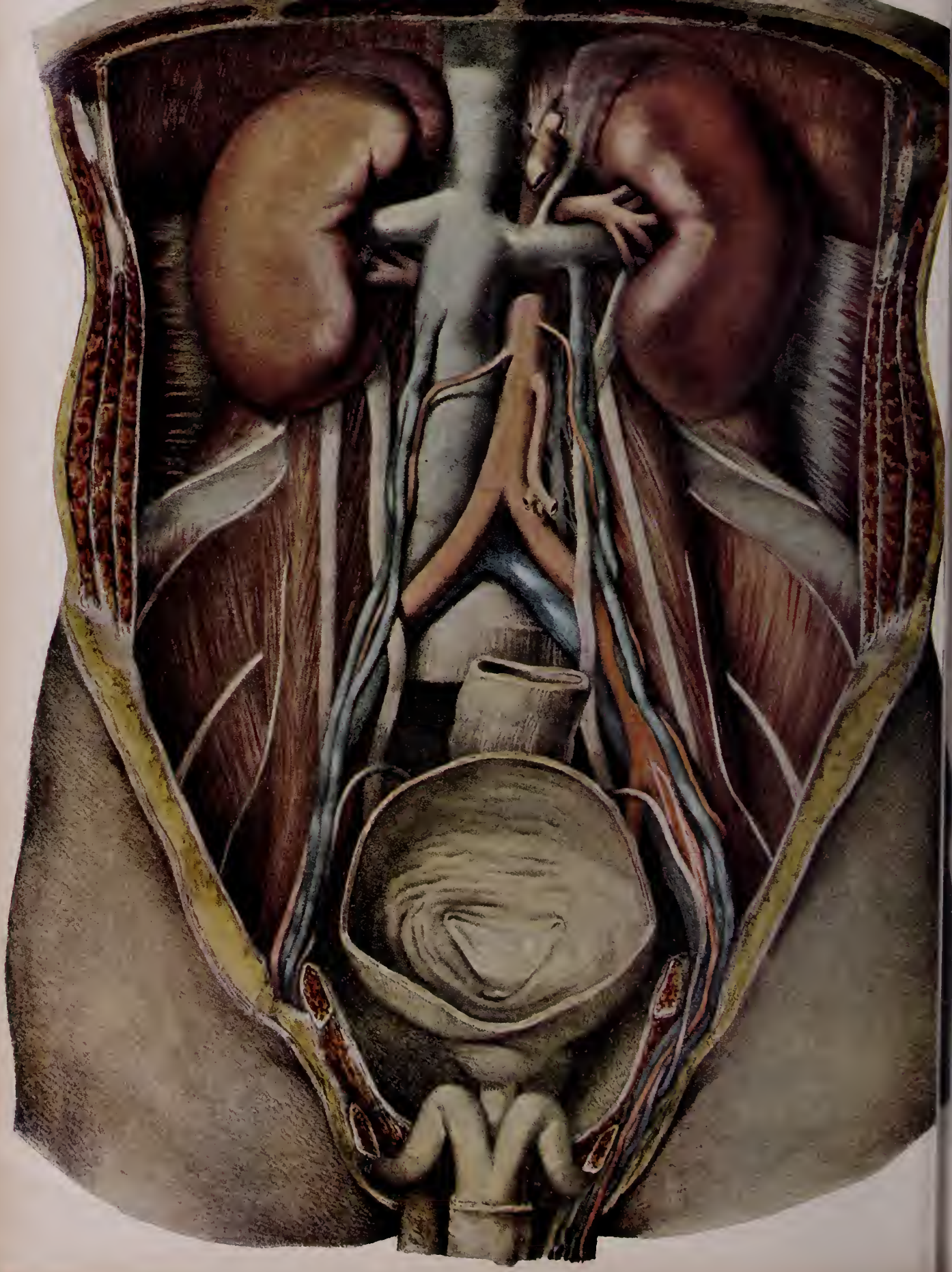
Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Tell patients who operate machinery or motor vehicles that drowsiness may result.

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Normally produces high and persistent levels in blood and high concentrations in bile and urine.

Significant inherent stability.

**Exclusive of penicillinase-producing bacteria.*

Indications: Urinary tract infections, especially those caused by *E. coli*, *Proteus mirabilis*, and *Streptococcus faecalis* and *viridans;* respiratory infections caused by *H. influenzae*, pneumococci, streptococci, and nonpenicillinase-producing staphylococci; and gastrointestinal infections caused by *Shigella* and *Salmonella*, including *Sal. typhosa.*



Contraindications: Hypersensitivity to penicillin; infections due to penicillinase-producing staphylococci and other penicillinase-producing bacteria.

Precautions: If allergic reaction occurs, discontinue ampicillin and administer epinephrine, corticosteroids, antihistamines and/or pressor amines as indicated. Transient moderate elevation of SGOT values of undetermined significance was noted in a few infants. Liver and kidney function as well as hematopoietic tests are advisable during therapy, particularly in infants. As with other antibiotics, precautions should be taken against gastrointestinal superinfection. Safety for use in pregnancy has not been established.

Adverse Reactions: Occasional mild side effects as urticaria, skin rash, pruritus, diarrhea, nausea and vomiting. There have been no reports of blood dyscrasias, liver or kidney damage. Anaphylaxis has been reported.

Composition: Capsules, 250 mg.

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Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychatic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathamimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychaneuratics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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ORGANIZATION SECTION



Administering the oath of office to new KMA President Robert E. Pennington (right) is Hubert C. Jones, M.D., Berea, chairman of the Board of Trustees.

KMA Chooses Dr. Brockman New President-Elect

George F. Brockman, M.D., a native of Louisville, was named president-elect of the Kentucky Medical Association at the second session of the House of Delegates Wednesday evening, September 21, during the KMA Annual Meeting.



Dr. Brockman

Robert E. Pennington, M.D., London, was installed as president of the association during the same session. He succeeds Everett H. Baker, M.D., Louisville, in office.

Doctor Brockman is a former KMA Delegate to the American Medical Association, and has served as Vice-Speaker and more recently Speaker of the KMA House of Delegates. He received his medical education at the University of Louisville College of Medicine, graduating in 1935.

Following internship at Louisville General Hospital and a period of residency at Hazelwood Sanitorium, he worked with the Bureau of Local Health Services of the State Department of Health, serving as Health Officer in various demonstration counties. After receiving his M.S. in bacteriology and public health from the University of Kentucky, Doctor Brockman served from 1943 until the end of World War II as a U.S. Public Health Service Reserve Officer with the U.S. Coast Guard and Navy.

After being discharged from the service, Doctor Brockman returned to Kentucky to work for a time as Communicable Disease Consultant for the State Department of Health and enter private practice in association with Gaithel L. Simpson, M.D., 1961 KMA president. The two men established the Greenville Cancer Clinic, the first clinic in a rural area to be sponsored by the American Cancer Society.



Dr. Asman



Dr. Smith

Doctor Brockman was one of the earliest volunteers for Project Viet Nam, spending October and November of 1965 in the Provincial Hospital at Tan An. On September 29 he returned to work in Viet Nam.

Newly elected vice-presidents of KMA, chosen at the September 21 session of the House, are: Roy H. Moore, M.D., Louisville, Central; James C. Cantrill, M.D., Georgetown, Eastern; and James A. Harris, Paducah, Western. Henry B. Asman, M.D., Louisville, Secretary, and Keith P. Smith, M.D., Corbin, Treasurer, were re-elected at the final session of the House.



Dr. Hayes



Dr. Miller

Drs. Hayes and Miller Elected To Head Board of Trustees

Rex E. Hayes, M.D., Glasgow, who has served as vice-chairman of the Board of Trustees, was elected chairman of the Board at the September 22 meeting of the Board during the KMA Annual Meeting in Louisville. Joseph R. Miller, M.D., Benton, was named vice-chairman.

Doctor Hayes succeeds Hubert C. Jones, M.D., Berea. A graduate of the University of Louisville

School of Medicine in 1933, Doctor Hayes is serving as Chairman of the Barren County Board of Health, and is on the active staff of the T. J. Samson Community Hospital, of which he is a past president. He was a KMA vice-president from 1959-1960, from the Western region of the state. He was also re-elected to his post as Trustee from the sixth district.

Doctor Miller, who has served as president of the Marshall County Medical Society on three different occasions, and who has been a director of the First District of the Kentucky Academy of General Practice, succeeds Doctor Hayes in office.

Elected as trustees for three year terms were: George H. Sehlinger, M.D., Louisville, Fifth; Leroy C. Hess, M.D., Florence, Eighth; Douglas H. Jenkins; M.D., Richmond, Eleventh; and Ballard W. Cassady, M.D., Pikeville, Fourteenth; who will fill the unexpired term of James W. Archer, M.D., Paintsville, now deceased. E. C. Seeley, M.D., London, was elected to his first full three year term, after serving the unexpired term of Robert E. Pennington, M.D., now KMA President.



Dr. Cooper



Dr. Greathouse

Drs. Greathouse, Cooper Named To Head House of Delegates

Richard F. Greathouse, M.D., Louisville, assumed the office of speaker of the House of Delegates of KMA, as provided in the Bylaws, when at the second session of the House Wednesday evening, September 21, George F. Brockman, M.D., Greenville, resigned to be named the new president-elect of KMA.

Carl C. Cooper, M.D., Bedford, will serve as vice-president, filling the vacancy left by Doctor Greathouse's appointment as speaker. Terms of both offices are for three years.

Doctor Greathouse, elected vice-speaker of the House of Delegates in 1965, is past president of the staff of Children's Hospital, Chairman of the Pediatric Section of Methodist Hospital, President of the Louisville Pediatric Society, Vice-chairman of the Kentucky Chapter-American Academy of Pediatrics, Secretary-Treasurer of the Kentucky Educational Medical Political Action Committee, and a past delegate to KMA from the Jefferson County Medical Society.

Doctor Greathouse is a former editor of the Jefferson County Medical Society *Bulletin,* and is currently editor of *The Centaur,* official national publication of Alpha Kappa Medical Fraternity. He is a 1947 graduate of the University of Kentucky and received his medical degree from the University of Louisville in 1951.

Doctor Cooper is the former chairman of the KMA Senior Day Committee and a member of the KMA Council on Communications and Public Service. He is a past alternate delegate to the AMA, and served as the state Association's representative on the Kentucky Health Council.

A former Eastern Vice-President of the KMA he is a Director and past vice-president of the Kentucky Academy of General Practice and a member of the American Academy of General Practice. Doctor Cooper is a 1952 graduate of the University of Louisville School of Medicine.

Mrs. Kissinger New Pres.-Elect of KMA Woman's Auxiliary

Mrs. Charles C. Kissinger, Henderson, was chosen president-elect of the Woman's Auxiliary to KMA during the organization's annual Meeting in Louisville on September 20-22.

She will succeed Mrs. Raymond E. Jones, Louisville, who was installed as president during the meeting. The 1965-66 President Mrs. Robert J. Salisbury, Mt. Sterling, presided at this year's sessions at the Kentucky Hotel.

Other new officers elected were: Mrs. F. H. Hodges, Pikeville, first vice-president; Mrs. James A. Harris, Paducah, second vice president; Mrs. O. L. May, Danville, third vice president; and Mrs. Joseph B. Parker, Jr., Lexington, fourth vice president. Also elected were Mrs. C. E. Hornaday, Owensboro, recording secretary; Mrs. Charles K. Sergent, Louisville, corresponding secretary; and Mrs. William C. Durham, Louisville, treasurer.



Leaders in the KMA Woman's Auxiliary discuss organizational problems during the 1966 meeting at the Kentucky Hotel. From left to right are Mrs. Charles C. Kissinger, Henderson, president-elect; Mrs. Robert J. Salisbury, Mt. Sterling, immediate past president; and Mrs. Raymond E. Jones, Louisville, president. Mrs. Salisbury presided at this year's meeting.



Accepting the Distinguished Service Award at the President's Luncheon is W. Vinson Pierce, M.D., Covington, (left). Presentation was made by William H. Bizot, M.D., Louisville.



Award winners—John C. Baker, M.D., Berea, who received the KMA's Outstanding General Practitioner Award (left) and Archibald P. Cochran, Louisville, who was chosen to receive the R. Haynes Barr Award—are pictured at the speakers table at the President's Luncheon.

Drs. Pierce and Baker Honored With Top '66 KMA Awards

KMA's two highest awards were presented to W. Vinson Pierce, M.D., Covington, and John C. Baker, M.D., Berea, during the 1966 President's Luncheon on September 21.

Doctor Pierce, a former delegate to the AMA, recieved the Distinguished Service Award and Doctor Baker was given the Outstanding Practitioner Award.

Archibald Cochran, Louisville, a retired industrialist who is active in civic and charitable affairs, received the R. Haynes Barr Award for his contributions to medical progress.

Doctor Pierce, a long-time delegate to KMA from Campbell-Kenton County, graduated from the University of Louisville School of Medicine in 1934. He served as delegate to the AMA from 1956 to 1961 and is presently a member of the AMA's Committee on Insurance and Prepayment Plans and a member of the Joint Commission for the promotion of Voluntary Non-profit Prepayment Health Plans.

A past president of Kentucky Physicians Mutual, the Kentucky Chapter of American College of Surgeons, and the Kentucky Surgical Society, he has also served as secretary of the Campbell-Kenton County Medical Society and as chief of staff of each of four local hospitals. A urologist, he is a past member of the executive committee of the Southeastern Section of the American Urological Association.

A native of Clay County, Doctor Baker graduated from the University of Tennessee College of Medicine in 1928, after working his way through Berea, Maysville, and Eastern State colleges by selling books. When he came to Berea in 1936, over 50 per cent of the babies born in this area were delivered by midwives. He immediately started directing the pregnant women to the hospital and during the period from 1936 to 1964 he delivered approximately 9,000 babies.

In April, 1964 he suffered a rather severe coronary, but returned to work in August of that year and has had a rather limited practice since. During World War II, he was the only physician available to care for the patients in southern Madison County, Jackson, and Rockcastle counties.

Mr. Cochran's contribution to medicine and medical education evolved from his active positions as chairman of the Board of Trustees of the University of Louisville School of Medicine and past president of the University's Board of overseers, and as longstanding member of the corporation and Trustee of the John M. Norton Memorial Infirmary.

He was co-chairman and the driving force in the recently successful Louisville Bond Issue campaign which will provide the new medical-dental school complex. He continues as the Bond Issue Project's coordinator. Since his retirement as chairman of the board of Anaconda Aluminum Company, he has devoted his energies to civic affairs.

Dr. Norfleet, Prominent Somerset Physician Dies at 85

Carl Norfleet, M.D., 85, Somerset, passed away October 2, following a long illness.



Doctor Norfleet

Doctor Norfleet, who served many years as Counselor (now Board of Trustees) from the twelfth KMA district, was a veteran of the World War I Medical Corps.

Doctor Norfleet received the Distinguished Service Medal of the KMA in 1951, and was Vice President of the KMA in 1956.

One of the founders of the Rural Kentucky Medical Scholarship Fund, Doctor Norfleet was serving as a member of the Board of Trustees of the Fund at the time of his last illness.

Following his retirement from active surgery, he served several years as a public health officer.



New KMA Commission Meets

At the September 22 Reorganization Meeting of the KMA Board of Trustees a Commission was named to make an indepth study of the organization and operation of the Association. Attending the first meeting of the Commission were the following physicians and staff members—starting at the left—Walter Hume, Jr., Louisville; N. Lewis Bosworth, Lexington; Robert C. Long, Louisville, a guest; Rex E. Hayes, Glasgow, Executive Chairman of the Commission; Richard R. Slucher, Buechel; Mrs. Pat Hire, KMA Staff; Robert G. Cox, KMA Staff; Henry B. Asman, Louisville, Commission Chairman; F. J. L. Blasingame, Chicago an Executive Vice President of the AMA who addressed the Commission; J. P. Sanford, KMA Staff; Robert E. Pennington, London; John C. Quertermous, W. Vinson Pierce, Covington; Joseph R. Miller, Benton and Everett H. Baker, Louisville. Members of the Commission not shown, are Keith P. Smith, Corbin, who had to leave early; George P. Archer, Prestonsburg, who was ill; George F. Brockman, Greenville, who is in Vietnam; and George A. Sehlinger, Louisville, who was out of town.

Annual Scientific Seminar Scheduled By Jewish Hospital, Nov. 17

Philip Kramer, M.D., Associate Professor of Medicine and Chief, Section on Gastroenterology, Boston University School of Medicine, will be guest speaker at the Second Annual Louisville Jewish Hospital Scientific Seminar, Thursday, November 17 at Rankin Amphitheater in General Hospital.

The day-long program gets underway at 9:00 A.M. and will include six scientific presentations. This program is acceptable for five accredited hours by the American Academy of General Practice.

Doctor Kramer will speak twice. His two talks are "Benign Diseases of the Esophagus", at 11:15, and "Management of Ulcerative Colitis" at 2:45, according to George Y. Shpilberg, M.D., Chief of the Department of General Practice at Jewish Hospital.

Nominating Committee Chosen

The Association's House of Delegates chose a five-man nominating committee to nominate the top KMA officers for 1967-68 at its final session on September 21.

Members of the nominating committee are: John S. Ashworth, M.D., Ashland; Harold B. Barton, M.D., Corbin; Robert L. McClendon, M.D., Louisville; Andrew M. Moore, M.D., Lexington; and W. Vinson Pierce, M.D., Covington. Chairman of the nominating committee will be chosen at the committee's first meeting at the Ken-Bar Inn, Gilbertsville, during the Interim Meeting on April 19-20.

Dr. Smith Appointed New Head Of Rehabilitation Center

Robert P. Smith, M.D., Burlington, Vermont, has been appointed to the post of director of the Rehabilitation Center in Louisville, it was announced by S. Gordon Dabney, president of the board of directors of the Center. Doctor Smith replaces Robert M. Izard, M. D., who resigned to become medical director of the Texas Rehabilitation Center.



Doctor Smith graduated from Princeton University in 1939 and received his M.D. degree from Harvard. He completed his residency at Mary Fletcher Hospital, Burlington, and was a clinical fellow in medical rehabilitation at Massachusetts General Hospital, and a research fellow at Harvard Medical School.

Doctor Smith was director of the Vermont Rehabilitation Center from 1956 to 1962, and for the past ten years he has been an instructor in medicine and physical medicine at the university of Vermont College of Medicine.



Three physicians off for a second tour of volunteer service in Vietnam are—left to right—George F. Brockman, M.D., Greenville, KMA president-elect; Stanley M. Gartska, M.D., Bakersfield, Cal., and Otto H. Heins, M.D., Raymondville, Tex. (far right). Pictured second from the right is Charles H. Moseley, M.D., director AMA Department of Government Services and Director, AMA Volunteer Physicians for Vietnam. Doctors Brockman, Gartska, and Heins will serve in Vietnam from October 3 to December 1.

Dr. Brockman Returns to Vietnam as Volunteer Physician

George F. Brockman, M. D., Greenville surgeon and recently named president elect of the KMA, left September 29 for San Francisco, enroute to Vietnam where he will stay for two months, helping in the American Medical Association Volunteer Physicians for Vietnam Program. This will be Doctor Brockman's second trip to Vietnam. Last year he left in early October for a two month stay in Vietnam.

Doctor Brockman explains his mixed feelings about his trip: "With all the medical problems we have here, I feel apologetic for leaving my patients and colleagues. However, when it developed that I could be useful in Vietnam again, I couldn't pass up another go at helping the fine Americans I had found doing such a good job for us there last year."

AMA Volunteer Physicians for Vietnam is a program for supplying medical care for the civilian population of South Vietnam through the volunteer services of U. S. physicians. It is administered by the AMA and financed by the U. S. Agency for International Development. Twenty-four to 32 physicians are needed every month to keep hospital staffs at full strength. Most needed are GP's, internists, and general and orthopedic surgeons.

For more information about the program contact: AMA Volunteer Physicians for Vietnam, AMA, 535 North Dearborn, St., Chicago, Ill. 60610.

'67 Annual Meeting Dates Chosen

September 26, 27, and 28 are the dates for the 1967 Annual Meeting of the KMA which is again scheduled to be held in Louisville.

Scientific sessions and exhibits will be in the Convention Center and headquarters for the meeting will be the Kentucky Hotel. Robert E. Pennington, M.D., London, KMA president and chairman of the Council on Scientific Assembly, is scheduled to meet with the Council this month to discuss preliminary plans for the 1967 meeting.

For Australian Convention

Carroll L. Witten, M.D., and Mrs. Witten departed early last month for Boston to attend the American Academy of General Practice, taking place October 10-13. At the meeting Doctor Witten was to be inagurated president of the Academy.



Doctor Witten

Immediately after the inaguration the Wittens were scheduled to leave for Australia, where Doctor Witten was to deliver an address to the Third General Practitioners Convention in Adelaide.

After several more stops, the Wittens will return to Louisville in mid-November. In September Mrs. Witten served as a delegate to the Annual Meeting of the Kentucky Medical Association, and Doctor Witten returned to Louisville recently from Salzburg, Austria, where he delivered an address to the International Congress of General Practitioners.

KMA 1966 Faculty Awards Go To Doctor Berman and Straus

Leonard Berman, M.D., associate professor of medicine and chief of the section on Renal Diseases at the University of Louisville, and Robert Straus, Ph.D., professor and chairman of the department of Behavioral Science at the University of Kentucky, were given the 1966 KMA Faculty Scientific Achievement awards at the President's Luncheon.

Presentation of the awards, which were given for the first time in 1962, was made by William Bizot, M.D., chairman of the KMA Awards Committee. Award winners are selected by the KMA Council on Medical Education and Hospitals and are presented to a faculty member from each of the two medical schools who has done outstanding research or made contributions of equal importance.

Doctor Berman, who first became associated with U of L School of Medicine in 1963, has "brought to a successful operational level, a vigorous and active program in renal transplants, renal dialysis, and an effective research program in nephrology." He has an international reputation in renal medicine and renal physiology.

Doctor Straus was cited for his wide range of teaching functions and development of an outstanding program for graduate students in the field of Behavioral Sciences. The citation stated he has "been a leader in the University Community and his services have been requested a number of times on critically important committees.

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"Can the Best be Better?" asks Walter H. Judd, M.D., former U.S. Congressman and medical missionary, featured speaker at the President's Luncheon during the 1966 Annual Meeting.

Physicians Urged to Do Better by Dr. Judd at Pres. Luncheon

Physicians were urged to continue in the pursuit of excellence using the 10 Principles of Medical Ethics as their guide by former Congressman Walter H. Judd M.D., who spoke to an overflow crowd of 400 at the 1966 President's Luncheon.

Attendance at the luncheon broke all previous records.

The former medical missionary and long-time Congressman from Minnesota warned that there are those who "seek to persuade the people that their trust and confidence in medical matters would better be placed in the government than in the profession".

He said that in order to maintain public trust and confidence, physicians must do better. Calling medicine the "queen of the professions", he urged individual physicians to join together to bring about the renaissance in the profession needed to meet the challenge to freedom.

Doctor Judd was the keynote speaker at the 1960 Republican National Convention, recieved the AMA Distinguished Service Award in 1961, The Medico World Humanitarian Award in 1962, and the U.S. Chamber of Commerce Great Living American Award in 1963.

AMA Dues

The House of Delegates of the American Medical Association voted to increase its 1967 annual dues from $45 to $70. This action was taken after voting at the 1965 Clinical Meeting to study the matter six months. Each KMA County Medical Society will receive information on this and related matters later this month, as is customary.

Initial Management of Trauma

"Initial Management of Trauma" is the theme of the ninth annual Norton Seminar on Thursday, December 15, in Louisville, which will feature three guest speakers according to Robert Lich, Jr., M.D., Louisville, program chairman.

Featured on the program of the seminar, which is co-sponsored by the Norton Memorial Infirmary and the Kentucky Academy of General Practice, will be Lt. Comdr. Kenneth F. Spence, USN, Bethesda, Md.; Basil A. Pruitt, MD., Fort Sam Houston, Tex.; and John H. Davis, M.D., Cleveland, Ohio.

All physicians are cordially invited to attend the seminar which will also include talks by members of the Norton staff. No registration fee will be charged. The seminar is scheduled to start at 10 a.m. at the Norton Memorial Infirmary.

"Emergency Care in Vietnam" will be explored by Lt. Comdr. Spence, who is on the staff of the Bethesda Naval Hospital. Doctor Pruitt, of the Brooke Army Medical Center, Fort Sam Houston, will discuss "Initial Treatment of Burns". "Resuscitation of the Patient with Multiple Injuries" is to be the topic of Doctor Davis, who is professor and director, department of surgery, Cleveland Metropolitan General Hospital.



Receiving special recognition for service to KMA at the 1966 President's Luncheon was long-time employee Miss Violet Stilz, Louisville, who retired in July after 43 years with the Association.

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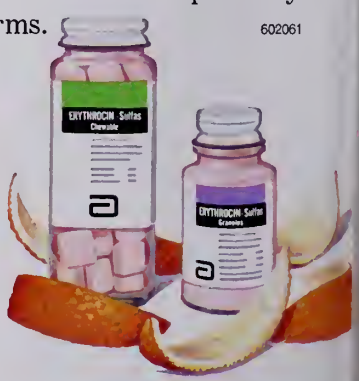
The acceptance: The majority of the 142 patients studied expressed a definite liking for the products. *There were only two refusals.* An independent taste-test with 50 healthy children further substantiated the excellent acceptability of the orange-flavored forms.

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Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

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At the close of the second session of the KMA House of Delegates on Wednesday, September 21, Vice Speaker Richard F. Greathouse, M.D., Louisville (far left) got together with reference committee chairmen. Shown (l to r) are—Irving F. Kanner, M.D., Lexington; W. Vinson Pierce, M.D., Covington; Walter I. Hume, Jr., M.D., Louisville; Fred C. Rainey, M.D., Elizabethtown; Carl Cooper, M.D., Bedford; Paul J. Parks, M.D., Bowling Green; and Bryant, M.D., Louisville.



W. Vinson Pierce, M.D., Covington, chairman of Reference Committee No. 6, Constitution and By-laws, (standing—center foreground), reports to the second session of the House of Delegates.



Seated at the speakers table at the third annual KMA Orientation Course held at the Kentucky Hotel during the 1966 Annual Meeting are—l to r—Henry B. Asman, M.D., Louisville, KMA secretary; Robert E. Pennington, M.D., London, KMA president-elect; Everett H. Baker, M.D., Louisville, KMA president; N. Lewis Bosworth, M.D., Lexington, chairman; and Mrs. Robert J. Salisbury, Mt. Sterling, president, Woman's Auxiliary to KMA.



Featured speakers at the annual KEMPAC Seminar on September 19—Senators Paul J. Fannin (R.-Ariz) standing —and Daniel K. Inouye (D.-Hawaii)—are shown with Mrs. Richard F. Greathouse, Louisville. Doctor Greathouse is secretary of the KEMPAC Board of Directors.

Annual KEMPAC Seminar Features Senators Fannin, Inouye

Medical legislation and its relation to the medical profession was discussed by two U. S. Senators with different viewpoints of the problems involved — Senator Paul Fannin (R-Ariz.) and Senator Daniel K. Inouye (D-Hawaii) — featured speakers at the fourth annual KEMPAC banquet on September 19.

"Future Legislative National Programs Relating to Medicine" was the theme of the conference. Sharing the spotlight with the two senators was George J. Lawrence, Jr., M. D., Flushing, N. Y., represening the American Medical Political Action Committee (AMPAC).

Approximately 200 physicians and their guests attended this year's seminar at the Kentucky Hotel. A KEMPAC workshop for doctor's wives preceded the seminar. Harold B. Barton, M. D., Corbin, chairman of KEMPAC Board of Directors, presided at the seminar. Everett H. Baker, M. D., Louisville, KMA president, also made a few brief remarks.

Winners of Annual KMGA Tournament for 1966

C. J. Scalzitti M.D., Louisville, was the winner of the KMGA Championship trophy at the annual golf tournament at the Louisville Country Club in Louisville, during the Association's 1966 Annual Meeting.

James B. Douglas, M.D., Louisville, tournament chairman, announced the winners, who also included: W. J. Graul, M.D., Versailles, Low Net Winner; Harold B. Graves, M.D., Louisville, Senior Division Champion; and Glen W. Bryant, M.D., Louisville, Low Net Senior Division Winner.

Next year's tournament is tentatively scheduled for the Standard Country Club of Louisville. All golfers are urged to make plans to participate in the 1967 tournament, to be held Monday, September 25, 1967.

Ob-Gyn District V Meets, Presents Awards in Louisville

Over 300 physicians and 600 nurses attended the October 12-15 meeting of District V, American College of Obstetrics and Gynecology in Louisville at Stouffers Inn. The session was termed very successful by Edwin P. Solomon, Jr., M.D., Louisville, chairman of the District's Kentucky Section.

The meeting was preceded by a session for the Junior Fellows of the College, one of whom, Charles R. Oberst, M.D., Louisville, shared honors for the annual Ephriam McDowell Award. Ninety-two physicians appeared on the Ob-Gyn nurses' portion of the program.

John D. Gordinier, M.D., Louisville, was chairman of the Local Arrangements Committee and a number of other Kentucky physicians helped plan or appeared on the program.

Dr. Gumbert Heads Flying Doctors

George M. Gumbert, Jr., M. D., was elected president-elect of the Flying Physicians Association at the Association's Annual Meeting in Las Vegas, September 11-16. A member of the Fayette County Medical Society, the KMA and the AMA, Doctor Gumbert graduated from the University of Louisville School of Medicine in 1953.

The Flying Physicians Association, organized in 1954 to promote safety in general aviation within the medical profession, presently has more than 1,800 members living in all 50 states, as well as in several foreign countries.

Dr. Slabaugh Elected

Raymond M. Slabaugh, Jr., M.D., Lexington was elected the new president of the Kentucky Urological Society to succeed Herman E. Martin, M.D., Ashland at the annual business meeting held during the 1966 Annual Meeting.

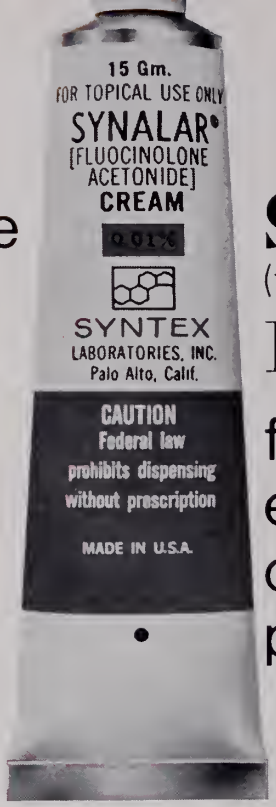
Secretary for the coming year for the society is Avrom M. Isaacs, M.D., Louisville. Henry I. Berman, M.D., Louisville, was the 1964-65 president.

14 Ky. M.D.'s New ACS Fellows

Fourteen Kentucky physicians were inducted as new Fellows of the American College of Surgeons during its five-day Clinical Congress in San Francisco, Cal., on October 13.

Those from Kentucky receiving this distinction were: Maj. Edwin C. McDaniel, MC, USA, Fort Knox; Robert D. Eastridge, M.D., Lebanon; John M. Allen, M.D., Lester R. Bryant, Jr., M.D., Loren J. Humphrey, M.D., James E. Ross, M.D., and Paul M. Weeks, M.D., all of Lexington; Berel L. Abrams, M.D., E. Dean Canan, M.D., Martyn A. Goldman, M.D., E. Truman Mays, M.D., and Harry D. Stambaugh, all of Louisville; William H. Hosbach, M.D., Paducah; and Robert A. Hall, M.D., Paintsville.

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of extensive areas, systemic absorption of the corticosteroid may occur, and suitable precautions should be taken. Occasional patients may show contact sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, or pyodermas have been seen infrequently with the use of this technique. The development of infection requires appropriate antibacterial therapy and discontinuation of the occlusive dressing method. Local atrophy and striae have been reported with protracted occlusive dressing therapy. While lesion relapses can be expected to occur in many psoriatic patients, remissions may persist for several weeks to several months in favorable cases. The patient whose psoriasis is in an active stage, with recent appearance of new lesions, may not be a good candidate and may show early relapse. Some plastic films may be flammable, and due care should be exercised in their use. Similarly, caution should be employed when such films are used on or left near children to avoid the possibility of accidental suffocation. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. **References:** 1. Cahn, M. M., and Levy, E. J.: J New Drugs 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O.: J Irish Med Ass 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Dunseath, W. J. R.: Southern Med J 56:797 (Jul.) 1963.

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First official act of newly elected president Robert E. Pennington, M.D., London, was presentation of a plaque for outstanding service to the Association to outgoing President Everett H. Baker, M.D., Louisville.



The camera man was able to get newly elected KMA officers together for a picture at the conclusion of the Wednesday evening meeting of the KMA House of Delegates. Shown from l to r are—George F. Brockman, M.D., Greenville, president-elect; Keith P. Smith, M.D., Corbin, who was re-elected to a three-year term as treasurer; Robert E. Pennington, M.D., London, president; and Henry B. Asman, M.D., Louisville, who was re-elected to a three-year term as secretary.



Escorting KMA President-Elect George F. Brockman, Greenville, to the podium at the final session of the KMA House of Delegates are David M. Cox, M.D., Louisville, and Everett H. Baker, M.D., Louisville, KMA president.



Presiding at the first general session of the KMA Annual Meeting at the Convention Center was President Everett H. Baker, M.D., Louisville, shown during opening ceremonies in the assembly hall.



Entertaining at the Kempac Banquet are, from left to right: Mrs. Elmer Prewitt, Mrs. A. S. Holmes, Mrs. Harry Hamilton, Mrs. Harold Barton, Mrs. Dodson Pitman, Mrs. B. H. Wells, and not shown on the picture, Mrs. Keith P. Smith, accompanist. All are from Corbin except Mrs. Pitman, from Williamsburg. All are wives of physicians.



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KMA membership has grown in the past year to another all-time high. The total of active physicians in the state who were active members of KMA was 2,235 as compared to 2,212 last year, according to records of the membership department.

Last year at this time a record was also set for increase in membership. This year 66 counties show 100 per cent KMA membership and 46 counties have 100 per cent membership—this also represents an AMA increase over last year when 64 counties had 100 per cent KMA membership and 37 had 100 per cent AMA membership.

Figures on the chart which follows includes membership records as of October 20. Associate and emeritus members are not included.

Number of Active Physicians in Kentucky Counties Who Are Members of KMA and AMA

October 20, 1966

COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA	COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA	COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA
Adair	8	7	6	Graves	15	14	14	Menifee	2	1	1
Allen	6	5	5	Grayson (*) (**)	5	5	5	Mercer (*)	12	12	11
Anderson	4	1	1	Green (*) (**)	6	6	6	Metcalfe (*) (**)	1	1	1
Ballard	6	4	4	Greenup (*) (**)	9	9	9	Monroe (*) (**)	7	7	7
Barren	23	22	21	Hancock	2	1	0	Montgomery (*)	9	9	6
Bath	3	2	1	Hardin (*)	26	26	23	Morgan (*)	4	4	2
Bell	26	17	16	Harlan	40	36	36	Muhlenberg	13	12	11
Boone (*) (**)	13	13	13	Harrison	8	7	3	Nelson (*) (**)	9	9	9
Bourbon (*)	17	17	12	Hart (*) (**)	6	6	6	Nicholas (*) (**)	3	3	3
Boyd (*) (**)	50	50	50	Henderson	24	20	20	Ohio (*) (**)	6	6	6
Boyle	21	16	13	Henry (*) (**)	3	3	3	Oldham	8	7	7
Bracken (*) (**)	2	2	2	Hickman (*) (**)	2	2	2	Owen	3	2	2
Breathitt (*) (**)	3	3	3	Hopkins	37	35	34	Owsley (*) (**)	2	2	2
Breckinridge (*)	5	5	4	Jackson (*)	2	2	1	Pendleton (*)	3	3	2
Bullitt (*) (**)	6	6	6	Jefferson	854	758	654	Perry	17	16	15
Butler (*) (**)	2	2	2	Jessamine (*)	5	5	3	Pike	52	24	23
Caldwell	6	5	5	Johnson	12	11	11	Powell	2	1	1
Calloway (*) (**)	15	15	15	Kenton	89	85	81	Pulaski (*)	26	26	25
Campbell	59	57	48	Knott (*) (**)	2	2	2	Robertson	1	0	0
Carlisle (*) (**)	2	2	2	Knox	7	6	3	Rockcastle (*) (**)	2	2	2
Carroll (*)	5	5	4	Larue	4	3	1	Rowan	10	9	9
Carter	3	2	1	Laurel	9	8	8	Russell (*) (**)	4	4	4
Casey (*) (**)	5	5	5	Lawrence (*) (**)	7	7	7	Scott (*)	10	10	3
Christian	37	31	31	Lee (*) (**)	2	2	2	Shelby (*) (**)	8	8	8
Clark	15	13	12	Leslie	3	0	0	Simpson (*) (**)	6	6	6
Clay (*) (**)	5	5	5	Letcher	17	8	8	Spencer (*) (**)	2	2	2
Clinton (*) (**)	2	2	2	Lewis (*)	2	2	1	Taylor	7	6	6
Crittenden (*) (**)	2	2	2	Lincoln (*) (**)	3	3	3	Todd (*) (**)	3	3	3
Cumberland (*) (**)	2	2	2	Livingston (*) (**)	3	3	3	Trigg	6	5	5
Daviess (*)	67	67	65	Logan (*) (**)	11	11	11	Trimble (*) (**)	2	2	2
Edmonson (*) (**)	2	2	2	Lyon (*) (**)	1	1	1	Union	6	5	5
Elliott (*) (**)	2	2	2	McCracken	55	52	50	Warren	41	39	38
Estill (*)	5	5	4	McCreary (*) (**)	2	2	2	Washington (*) (**)	4	4	4
Fayette	372	288	263	McLean	4	3	0	Wayne (*)	6	6	5
Fleming (*)	4	4	1	Madison	26	25	21	Webster	6	5	5
Floyd	22	11	10	Magoffin	2	1	0	Whitley (*)	19	19	12
Franklin	34	30	29	Marion	9	8	8	Wolfe (*) (**)	1	1	1
Fulton	10	9	9	Marshall (*) (**)	10	10	10	Woodford	9	6	2
Gallatin	1	0	0	Martin	2	1	1				
Garrard (*)	4	4	3	Mason	14	12	9	Total —	2553	2235	2003
Grant (*) (**)	4	4	4	Meade (*)	3	3	1				

* 100% KMA ** 100% AMA

Note: Report includes teaching staffs at medical schools, physicians in public health, mental institutions, TB hospital, VA hospital, etc.

COMPARATIVE REGISTRATION FIGURES

KMA Annual Meetings

	Louisville 1957	Louisville 1958	Louisville 1959	Louisville 1960	Louisville 1961	Louisville 1962	Lexington 1963	Louisville 1964	Louisville 1965	Louisville 1966
KMA Members	1094	971	997	1021	996	1014	865	924	1172	1016
Guest Physicians	178	166	165	203	194	208	141	157	138	195
Interns-Residents	142	108	128	105	102	102	69	108	132	121
Medical Students	328	269	280	289	237	176	59	128	193	209
Registered Nurses	28	22	34	25	31	59	31	34	27	33
Exhibitors	176	211	200	239	204	232	212	297	297	312
Guests	151	164	86	99	132	123	132	125	172	126
Technicians—					57	71	22	61	55	46
Office Assistants	54	45	63	33						
TOTAL ATTENDANCE	2151	1956	1953	2014	1953	1985	1531	1844	2186	2058

STOP anxiety

but not your patient

For your anxious patients who must remain active, 'Stelazine' offers a specific, incisive antianxiety effect that can calm excessive anxiety without producing annoying dulling effects. On 'Stelazine' patients react more normally to stresses and at the same time remain alert enough to carry on their normal activities.

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brand of **trifluoperazine**

Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. The following is a brief precautionary statement. *Contraindications:* Comatose or greatly depressed states due to C.N.S. depressants and in cases of existing blood dyscrasias, bone marrow depression and liver damage. *Precautions:* Use with caution in angina patients and in patients with impaired cardiovascular systems. Antiemetic effect may mask symptoms of other disorders. An additive depressant effect is possible when used with other C.N.S. depressants. Prolonged administration of high doses may result in accumulative effects with severe C.N.S. or vasomotor symptoms. Use in pregnant patients only when necessary for the patient's welfare. *Side Effects:* Occasional cases of mild drowsiness, dizziness, mild skin reactions, dry mouth, insomnia and amenorrhea. Neuromuscular (extrapyramidal) reactions (motor restlessness, dystonias, pseudo-parkinsonism) may occur and, in rare instances, may persist. In addition, muscular weakness, anorexia, rash, lactation, hypotension, and blurred vision have been observed. Blood dyscrasias and cholestatic jaundice have been extremely rare. For a comprehensive presentation of 'Stelazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

Smith Kline & French Laboratories. Philadelphia

Among Important Matters Discussed by KMA House of Delegates

Accepting the KMA's Board of Trustees recommendation for the state-wide confidential study of physicians' fees, establishing a new KMA Council on Governmental Medical Services, and approving an annual registration of physicians were among the more important actions taken by the KMA House of Delegates in its 115th meeting Wednesday evening, September 21, 1966.

The seven reference committees and their chairmen were highly praised by veteran KMA observers and officers for their effective work in presenting recommendations in one of the most important meetings ever held by the KMA House of Delegates, and doing so in near record time.

All reports and resolutions presented at the 1966 meeting, the recommendations of the seven reference committees and action of the House of Delegates will be published in the December 1966 issue of The Journal of KMA, Richard F. Greathouse, M.D., Louisville, speaker of the House said.

The resolution presented by the Board of Trustees of KMA calling for a state-wide confidential study of physicians' fees was passed by the House. The recommendation provided that the cost of the study, which would be made by the Kentucky Blue Shield, would be borne jointly by Blue Shield and the State Department of Health, with the KMA cooperating.

When this confidential study has been completed and predictability of cost can be established, it is expected that the State Department of Health will be able to compensate physicians on the usual and customary fee basis for services rendered to welfare patients.

With the establishment of the Council on Governmental Services by the House, the Association will now be able to better follow the developments of the many governmental medical care programs that are now being developed, and to exercise its influence in the implementation of these programs in the best interest of all concerned.

After refusing to accept similar recommendations at the 1963 and 1964 meetings, the House of Delegates this year voted to approve the principle of annual registration without a fee by the Division of Medical Licensure of the State Department of Health. Proponents of the measure said that the procedure would better enable the Division of Medical Licensure and the KMA to follow the movement of physicians in and out of Kentucky.

A recommendation from the KMA's Committee on Tuberculosis and the now defunct Council on Allied Professions and Related Groups calling for further fragmentation of services rendered by the State Department of Health was defeated.

The House of Delegates voted to commend the Kentucky Educational Medical Political Action Committee in its work and urged full support by all KMA members in joining KEMPAC and promoting its program.

The House of Delegates accepted a resolution from Fayette County Medical Society calling for direct billing in all governmental programs and providing "that all contracts made by the KMA with government agencies which are in conflict with the present Kentucky Medical Association policy be terminated as soon as practicable". Reference Committee No. 5, which considered this resolution, recommended that the KMA contact the Department of Health, Education and Welfare directly and promptly to determine if direct billing utilization of usual, customary and reasonable fees is at present possible under HEW regulations. This was also accepted.

A resolution introduced by the Jefferson County Medical Society recommending a study committee for coordinated health care was accepted in principle. The resolution authorized the President of KMA and the Speaker of the House of Delegates to appoint a committee to make the study. The House accepted a reference committee amendment to the resolution which read "And Be It Further Resolved, that KMA Study Committee for Improvement of Community Health utilize local community self study groups consisting of both physicians and lay organizations to study local medical problems".

A resolution from the Muhlenberg County Medical Society urging the State Selective Service System to select physicians to serve in the armed forces on the basis of ratio of physician to patient population within the age range prescribed by Selective Service was accepted.

The House amended Chapter IX, Section 3 of the Bylaws to read: "All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution."

David M. Cox, M.D., Louisville, has succeeded the late Lytle Atherton, M.D., as Medical Director for the Lincoln Income Life Insurance Company. Douglas Atherton, M.D., the late Doctor Atherton's son, has been made a member of the Board of Directors of the Company.

Mitchell B. Denham, M.D., Maysville, is the recipient of the Maysville Rotary Club Award for Outstanding Community Service. The award, presented by Frank E. Moore, governor of Rotary District No. 40, points out that Doctor Denham was instrumental in getting a new UK Community College in Maysville.



Butazolidin® alka

phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
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Tomsk
Kemerovo
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Kyzyl
Irkutsk
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Blagoveshchensk
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Murmansk
Arkhangelsk
Severodvinsk
Onega
Petrozavodsk
Kirov
Kostroma
Yaroslavl
Rybinsk
Cherepovets
Vologda
Arkhangelsk
Kotlas
Syktyvkar
Ukhta
Vorkuta
Salekhard
Igarka
Norilsk
Dudinka
Tiksi
Pevek
Anadyr
Petropavlovsk
Yuzhno-Sakhalinsk
Nakhodka
Vladivostok
Khabarovsk
Komsomolsk
Magadan
Yakutsk
Chita
Ulan-Ude
Irkutsk
Bratsk
Ust-Ilimsk
Tayshet
Abakan
Kyzyl
Novosibirsk
Barnaul
Tomsk
Kemerovo
Omsk
Tyumen
Tobolsk
Surgut
Nizhnevartovsk
Khanty-Mansiysk

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.[3-8] Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."[3]

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action confirmed by gastric analyses and x-ray evidence of clinical effectiveness.[3,7,9-12] Relieves pain with "impressive" promptness.[8] Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, belching and other ulcer symptoms.[7] Suppression of nocturnal pain is "outstanding."[13] Maximally effective doses may be given with minimal side reactions, and the incidence of unwanted anticholinergic effects is negligible.[3,7-14]

no matter what the ulcer theory... the fact is that

Robinul®
(glycopyrrolate)
promotes the essential ulcer-healing environment

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(brief summary follows)

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(glycopyrrolate)
promotes the essential ulcer-healing environment

Indications: In addition to its primary indications for duodenal and gastric ulcer, Robinul (glycopyrrolate) is indicated for other GI conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.
Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.
Precautions: Administer with caution in the presence of incipient glaucoma.
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.
Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*
Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.
References: **1.** Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. **2.** Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. **3.** Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. **4.** Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. **5.** Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. **6.** Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. **7.** Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. **8.** Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. **9.** Epstein, J. H.: Ibid 37:295 (Mar.) 1962. **10.** Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. **11.** Slanger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. **12.** Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. **13.** Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. **14.** Fleshler, B.: J New Drugs 2:211 (Jul.-Aug.) 1962. **A. H. ROBINS CO., INC.**
Richmond, Virginia

Seven physicians have become new members of the Kentucky Medical Association, according to the records of the membership department. Following are the names of the new members as of October 11:

Maxwell C. Kimball, M.D., Lexington, Charles I. Fuller, Jr., M.D., Harlan, Robert S. Davis, M.D., Harlan, R. Kendall Brown, M.D., Georgetown, Charles W. Mercer, M.D., Murray, and S. Terrell Vanover, M.D., Shepherdsville, D. Vertrees Hollingsworth, M.D., Georgetown.

Dr. Wayne Named Acting Dean

According to U. of K. president John W. Oswald, Thomas P. Wayne, M. D., assistant vice president for the University of Kentucky Medical Center and associate dean of the College of Medicine, has been named acting dean of the College of Medicine.

Doctor Wayne will serve until a replacement for William Willard, M. D. can be found. Doctor Wayne graduated from Washington University School of Medicine and has been active in KMA Committee work.

In Memoriam

GEORGE BRADLEY
Elizabethtown
1901 - 1966

George Bradley, M.D., 65, Elizabethtown, past president of the Hardin County Medical Society and past president of the Muldraugh Hill Medical Society, died September 30 at Hardin Memorial Hospital, where he was chief of staff. Doctor Bradley was a member of KMA and of the AMA. He graduated from the University of Louisville School of Medicine in 1935 and interned at St. Elizabeth's Hospital in Covington, Kentucky.

JOHN O. SALYERS
Louisville
1879 - 1966

John O. Salyers, M.D., 87, former physician at the State Reformatory near La Grange, died September 19 at Methodist Evangelical Hospital in Louisville. Doctor Salyers graduated from Northwestern University. He practiced in Hazard until receiving the post of full-time physician at the reformatory in 1945.

ELMER R. SMITH, M.D.
Somerset
1910-1966

Elmer R. Smith, 56, Somerset, who limited his practice to internal medicine, died September 25 at Somerset. Doctor Smith had practiced in South Central Kentucky for many years. He served in the medical corps during two wars. A member of KMA, Doctor Smith graduated from Ohio State University College of Medicine in 1936.

Was Your Delegate Present?

ROLL CALL—

1966 House of Delegates

KMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	George F. Brockman	Present	Present
Vice-Speaker	Richard F. Greathouse	Present	Present
President	Everett H. Baker	Present	Present
President-Elect	Robert E. Pennington	Present	Present
Vice-President	George W. Pedigo	Present	Present
Vice-President	Donald K. Dudderar	.....	.....
Vice-President	C. C. Lowry	.....	Present
Secretary	Henry B. Asman	Present	Present
Treasurer	Keith P. Smith	Present	Present
Delegate to the AMA	J. Thomas Giannini	.....	Present
Delegate to the AMA	Charles C. Rutledge	Present	Present
Delegate to the AMA	John C. Quertermous	Present	.....
Alternate Delegate to the AMA	Charles G. Bryant	Present	Present
Alternate Delegate to the AMA	William W. Hall	Present	Present
Alternate Delegate to the AMA	David B. Stevens	Present	Present

TRUSTEES

District			
First	Joseph R. Miller	Present	Present
Second	W. Gerald Edds	.....	.....
Third	Gabe A. Payne	.....	.....
Fourth	Henry S. Spalding	.....	.....
Fifth	Alfred O. Miller	.....	.....
Sixth	Rex E. Hayes	Present	Present
Seventh	Donald Chatham	Present	.....
Eighth	W. Donald Janney	.....	.....
Ninth	Mitchell B. Denham	Present	Present
Tenth	Douglas E. Scott	Present	Present
	Hubert C. Jones	Present	Present
Twelfth	Robert F. Long	.....	Present
Thirteenth	Walter L. Cawood	Present	Present
Fourteenth	James W. Archer (Deceased)		
Fifteenth	E. C. Seeley	Present	Present

PAST PRESIDENTS

Past President	Delmas Clardy	Present	Present
Past President	George P. Archer	Present	.....
Past President	David M. Cox	Present	Present
Past President	Gaithel L. Simpson	.....	Present
Past President	R. G. Elliot (Deceased)		
Past President	Irvin Abell, Jr.	.....	.....

DELEGATES

		First Session	Second Session
First District			
County			
BALLARD	Glenn Baird	.....	.....
CALLOWAY	Thomas L. Parker	.....	.....
CARLISLE	John T. O'Neill	.....	.....
FULTON	R. W. Bushart	.....	.....
GRAVES	A. Reeves Morgan	.....	.....
HICKMAN	C. J. Mills	.....	.....
LIVINGSTON			
McCRACKEN	James Harris	Present	Present
	W. B. Haley	Present	Present
	Winfield Stryker	.....	.....
MARSHALL	Wendell E. Gordon	.....	Present
Second District			
DAVIESS	Reginold J. Phillips	Present	Present
	J. H. Kurre	.....	Present
	J. S. Oldham	Present	.....
	A. H. Hopwood (Alternate)	Present	.....
HANCOCK			
HENDERSON	Charles Kissinger	Present	Present
McLEAN	Samuel Scott	.....	.....
UNION	Jerry McKenney	.....	.....
WEBSTER	Paul Taylor	Present	Present
Third District			
CALDWELL	Frank P. Giannini	.....	.....
CHRISTIAN	W. Faxon Payne	Present	Present
CRITTENDEN	Norma T. Shepherd	.....	.....
HOPKINS	Loman C. Trover	Present	Present
	Frederick Scott	Present	Present
LYON	James E. Hamilton	.....	.....
MUHLENBERG	Robert Robbins	Present	Present
TODD	Ralph D. Lynn (Alternate)	Present	Present
TRIGG	Elias N. Futrell	Present	.....
	Thornton Bryant (Alternate)	.....	Present
Fourth District			
BRECKINRIDGE	James G. Sills	Present	.....
BULLITT	James Roney	.....	.....
	W. B. Hamilton (Alternate)	Present	.....
GRAYSON	C. L. Bland	.....	.....
GREEN	Robert P. Simmons	.....	.....
HARDIN	Fred C. Rainey	Present	Present
HART			
LARUE	Marion Douglas	Present	.....
MARION	John W. Ratliff	Present	Present
MEADE			
NELSON	Tyre Forsee	Present	.....
SPENCER	W. K. Skaggs	.....	.....
TAYLOR	M. M. Hall	Present	Present
WASHINGTON	H. B. Simms	Present	.....
	Dixie Snider (Alternate)	.....	Present
Fifth District			
JEFFERSON	Harold Eskind	.....	Present
	Wilfrid Gettelfinger	Present	Present
	David Kinnaird	.....	.....
	Edmond P. Solomon (Alternate)	.....	Present
	John Doyle	.....	.....
	Charles Sergent (Alternate)	Present	Present
	Robert McClendon	Present	Present
	James Marshall	Present	Present
	W. Fielding Rubel	Present	Present
	William Rumage	Present	Present
	Robert Stansbury	.....	Present
	Harry Stambaugh	Present	Present
	Eugene Conner	Present	Present
	Louis Foltz	Present	Present
	Richard Greathouse	Present	Present
	H. D. Haller (Alternate)	.....	Present
	John Harter	Present	Present
	W. I. Hume, Jr.	Present	Present
	Herman Moore	Present	Present
	K. P. Crawford	Present	Present
	Gerald Peterson	Present	Present
	George Sehlinger	Present	Present
	Melvin Bernhard	Present	Present
	Harold Baker	.....	.....
	William Durham	Present	Present
	John Goldsborough	Present	Present
	John Hemmer	.....	Present
	Herman Mahaffey	Present	.....
	Michael Cronen (Alternate)	.....	Present
	William Mitchell	Present	Present
	John Robbins	.....	Present
	Donn Smith	Present	.....
	Donald Varga	Present	Present
	William VonderHarr	Present	.....
	William Sandman (Alternate)	.....	Present
	Lloyd Yopp	Present	Present
Sixth District			
ADAIR	J. C. Salato	Present	Present
ALLEN	F. J. Halcomb	.....	.....
	Earl P. Oliver (Alternate)	Present	.....
	Owen L. Davis (Alternate)	.....	Present
BARREN	E. L. Marion	Present	Present
BUTLER	D. G. Miller	.....	.....
CUMBERLAND	Robert Chambliss	.....	.....
EDMONSON			
LOGAN	C. V. Dodson	Present	Present
METCALFE	L. P. Emberton	.....	.....
MONROE	W. R. Fushong	.....	.....
SIMPSON	A. V. Wilwayco	.....	.....
WARREN	Paul J. Parks	Present	Present
	Martin Wilson	Present	Present

**The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 19 and 21.*

	Seventh District		
ANDERSON	Boyd Caudill	.....	Present
CARROLL	Edgar S. Weaver	.....	.....
FRANKLIN	S. L. Weiler	Present	Present
GALLATIN	Harry J. Cowherd	Present	Present
GRANT	Lenore P. Chipman	Present	Present
HENRY	Wyatt Norvell	.....	Present
OLDHAM	James Kurfees	.....	.....
	H. Burlmack (Alternate)	Present	Present
OWEN			
SHELBY	Stephen F. Collins	Present	Present
TRIMBLE	Carl Cooper, Jr.	Present	Present
	Eighth District		
BOONE	L. C. Hess	Present	.....
	John Ammon (Alternate)	.....	Present
CAMPBELL-KENTON	Carl J. Brueggemann	Present	Present
	Donald K. Dudderar	.....	.....
	Paul Klingenberg	.....	Present
	W. Vinson Pierce	Present	Present
	Thomas L. Heavern	Present	Present
	Robert T. Longshore	Present	.....
	Ninth District		
BATH			
BOURBON	James L. Ferrel	Present	Present
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	Samuel W. Gehring	.....	.....
HARRISON	Henry H. Moody	.....	Present
MASON	H. N. Parker	.....	Present
NICHOLAS	W. R. Kingsolver	.....	.....
PENDLETON	Robert L. McKenney	.....	.....
ROBERTSON			
SCOTT	J. C. Cantrill	Present	Present
	Tenth District		
FAYETTE	Robert D. Shepard	.....	.....
	Donald E. Edger (Alternate)	Present	Present
	N. L. Bosworth	Present	Present
	Richard D. Floyd	Present	Present
	Carl H. Fortune	Present	Present
	John F. Berry	Present	Present
	A. M. Moore	Present	Present
	T. R. Bryant, Jr.	Present	Present
	Irvin F. Kanner	Present	Present
	J. H. Saunders	Present	Present
	David A. Hull	Present	Present
	Graydon A. Long	.....	.....
	R. B. McElvain (Alternate)	.....	Present
	L. W. Blackey	Present	Present
	John E. Myers	Present	Present
JESSAMINE	J. S. Williams	Present	Present
WOODFORD	Ben F. Roach	.....	.....
	Norman Fischer (Alternate)	Present	Present
	Eleventh District		
CLARK	Harold Moberly	.....	.....
ESTILL	Virginia Wallace	.....	.....
JACKSON			
LEE			
MADISON	William D. Epling	Present	.....
	Douglas Jenkins (Alternate)	Present	.....
MENIFEE	D. L. Graves	.....	.....
MONTGOMERY	R. L. Salisbury	Present	Present
OWSLEY			
POWELL	G. C. Noss	.....	.....
WOLFE	Paul F. Maddox	.....	.....
	Twelfth District		
BOYLE	John Baird	Present	.....
CASEY	Garnett Sweeney	Present	.....
CLINTON	Ernest A. Barnes	.....	.....
GARRARD	Paul E. Lett	Present	.....
LINCOLN	Edward C. Bowling	.....	.....
McCREARY	H. A. Perry	.....	.....
MERCER	Bacon R. Moore, III	.....	.....
PULASKI	William M. Wyatt	Present	Present
	B. L. Ramsay	.....	.....
	A. L. Cooper (Alternate)	Present	Present
ROCKCASTLE	George H. Griffith	.....	.....
RUSSELL	Charles E. Peck	.....	.....
WAYNE	Robert B. Breeding	.....	.....
	Thirteenth District		
BOYD	J. E. Stephenson	.....	.....
	J. S. Wheeler	.....	.....
CARTER	John Ashworth	Present	Present
ELLIOTT	John F. Greene	.....	.....
GREENUP	John O. Jones	Present	Present
LAWRENCE	William J. McNabb	.....	.....
	A. B. Richards (Alternate)	Present	Present
LEWIS			
MORGAN	George Bellamy	.....	.....
	Fourteenth District		
BREATHITT	Robert E. Cornett	.....	.....
FLOYD	James D. Adams	.....	.....
JOHNSON	A. B. Carter	.....	.....
KNOTT	G. T. Watts	.....	Present
LETCHER	Jim B. Tolliver	Present	.....
MAGOFFIN			
MARTIN	John W. Ford	.....	.....
	F. Calvin Bigler	Present	.....
	Billy Joe Caudill ((Alternate)	.....	Present
PERRY	Mary Pauline Fox	.....	.....
	Charles C. Rutledge (Alternate)	Present	.....
	D. L. Martin (Alternate)	.....	Present
PIKE	Harvey A. Page	Present	Present
	Fifteenth District		
BELL	Meredith Evans	Present	.....
CLAY	J. L. Becknell	Present	Present
HARLAN	Henry C. Evans	Present	Present
	Doane Fischer	Present	Present
KNOX	H. L. Bushey	Present	Present
LAUREL	Paul R. Smith	Present	Present
LESLIE			
WHITLEY	Harold B. Barton	Present	Present

1966 Annual Meeting Speakers Express Appreciation to KMA

"It was a pleasure to be invited to the Kentucky Medical Association Scientific Assembly. I particularly enjoyed participating in the television program and wish to thank you for the courtesies and hospitality shown. I enjoyed the President's Luncheon, the hotel room, and such pleasant touches as the basket of fruit provided."

Douglas W. Eastwood, M.D.
Professor of Anesthesiology
University of Virginia Hospital
Charlottesville, Va.

"I had a very pleasant trip and certainly enjoyed participating in the program."

Robert W. Weber, M.D.
Salina, Kansas

"It was a pleasure to participate in the 1966 Annual Meeting of the Kentucky Medical Association."

Eugene C. Klatte, M.D.
Professor and Chairman, Dept. of Radiology
Vanderbilt University Hospital
Nashville, Tennessee

"I enjoyed the opportunity of appearing before your association and wish to thank those officers responsible for my invitation."

Chester C. Winter, M.D.
Professor and Director, Div. of Urology
Ohio State University
Columbus, Ohio

"I certainly did enjoy my trip to Kentucky. It was nice to be in Louisville again and to recall the four years I lived there and to meet friends whom I had known in the old days and again more recently."

Carl A. Whitaker, M.D.
Professor of Psychiatry
University of Wisconsin Medical School
Madison, Wisc.

"It was a pleasure to participate in the 1966 Annual Meeting."

Leon Goldman, M.D.
Professor and Chairman, Dept. of Dermatology
University of Cincinnati College of Medicine
Cincinnati, Ohio

"I enjoyed the meeting very much and was very happy with the arrangements made for me."

John G. Gorman, M.D.
Director, Blood Bank
Presbyterian Hospital
New York, N.Y.

"I appreciate very much the fine hospitality shown me by your Association."

Samuel Saslaw, M.D., Ph.D.
Professor of Medicine and Microbiology
Ohio State University
Columbus, Ohio

"My sincere thanks for a most enjoyable visit with you at the recent Kentucky Medical Association meeting in Louisville, Kentucky. Your hospitality overwhelmed me."

Newton DuPuy, M.D.
President-Elect
Illinois State Medical Society
Chicago, Illinois

"I was very pleased to have been asked to participate in your state medical meeting and thoroughly enjoyed my rather brief stay in Louisville. I hope that I may be asked again some time in the future."

Thomas K. Oliver, Jr., M.D.
Professor of Pediatrics
Head, Division of Neonatal Biology
University of Washington
Seattle, Washington

"I want to thank you for your kindness to me while attending the KMA meeting. I appreciate more than you expect an opportunity to talk with you and receive the valuable information that you gave me. I was very much impressed with the organization and function of the KMA, and particularly with your Key-Man booklet.

"Please convey to the officers of the KMA my appreciation for the invitation to visit with you."

Alexander McCausland, M.D.
President-Medical Society of Virginia
Richmond, Virginia

"I wish to thank the Kentucky Medical Association for a most enjoyable meeting in Louisville."

Byron M. Stuart, M.D.
President-Missouri State
Medical Association
Boonville, Missouri

"All of you were most courteous to me personally and I wish to thank you again."

Walter H. Judd, M.D.
Washington, D. C.

(Continued on page 1062)

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FOR PROFESSIONAL RECOMMENDATION ONLY

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Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9, 10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

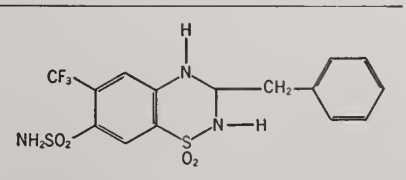
Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.



Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

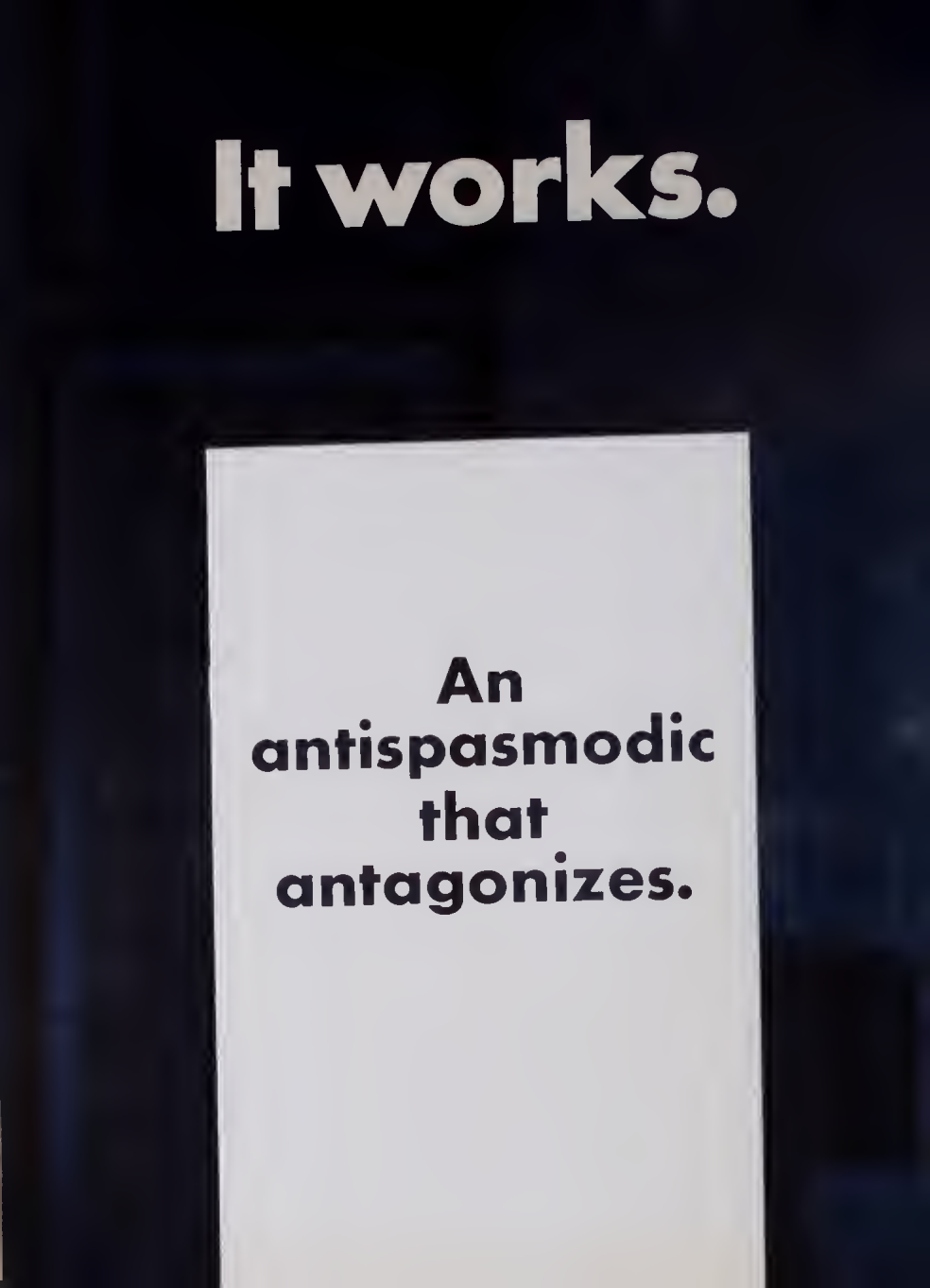
Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

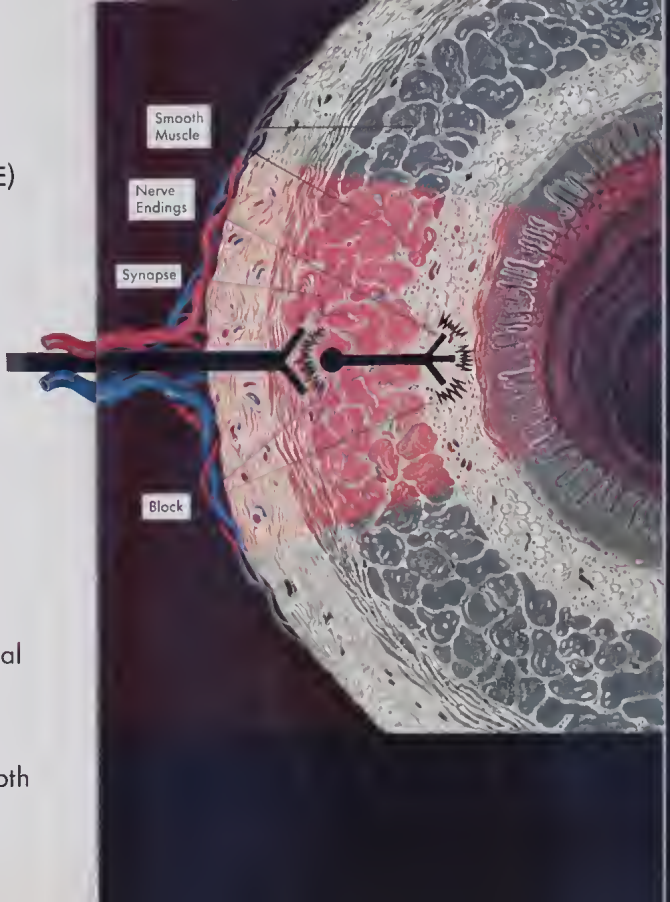
Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: 1. Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.

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to reduce excess fluid
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How TREST®
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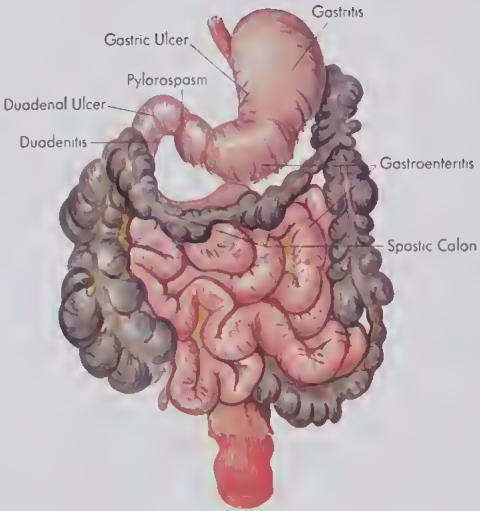


TREST (methixene hydrochloride) directly antagonizes the parasympathetic nervous system.

TREST (methixene hydrochloride) blocks the action of acetylcholine formed at the synapses and visceral parasympathetic nerve endings.

Therefore, nerve impulses are prevented from reaching the smooth muscle layer.

TREST® (METHIXENE HYDROCHLORIDE)
relieves gastrointestinal spasm, hyperactivity and associated pain in:



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with your prescription for
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t.i.d. dosage in milligrams

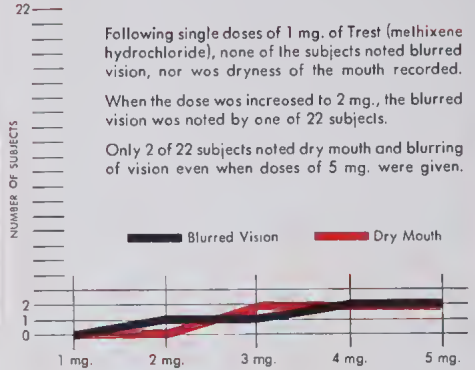
1 mg. symptomatic relief

2 mg. upper recommended clinical dose/greater pharmacologic activity and symptomatic relief/side effects uncommon

10 mg.

Studies with 372 subjects revealed no adverse effect upon vital organs when dosage was increased 10 times the normally effective dose of 1 mg. t.i.d. for periods up to 2½ years of continued administration.

LACK OF SIDE EFFECTS



Following single doses of 1 mg. of Trest (methixene hydrochloride), none of the subjects noted blurred vision, nor was dryness of the mouth recorded.

When the dose was increased to 2 mg., the blurred vision was noted by one of 22 subjects.

Only 2 of 22 subjects noted dry mouth and blurring of vision even when doses of 5 mg. were given.

Conclusion: Typical atropine-like side effects are not expected when Trest is used 1 mg. t.i.d. These effects are uncommon when the dosage is increased to 2 mg t.i.d.

"A highly satisfactory symptomatic response was obtained in 20 of the 23 patients who took 1 mg. of methixene hydrochloride (Trest) by mouth three times daily. No side effects occurred at this dosage during administration of the medication itself.

"Methixene hydrochloride (Trest) provides highly gratifying symptomatic relief in a variety of conditions associated with gastrointestinal motility without producing the usual atropine-like side effects and without requiring concurrent barbiturate sedation."
—Martins, J. K.
Clin. Med. 72:1313-1316
(Aug.) 1965

"... in a series of 47 patients suffering from various types of functional bowel distress. The superiority of this drug (Trest) in dosage of 1.0 mg. three times daily by mouth over the placebo is statistically significant. At that dosage level, side effects were not observed."
—Hufford, A. R.
Clin. Med. 72:1151-1155
(July) 1965.

SUMMARY:

TREST® (METHIXENE HYDROCHLORIDE) relieves G.I. spasm, hyperactivity and associated pain by directly antagonizing the parasympathetic nervous system.

Each tablet contains methixene hydrochloride, 1 mg.

INDICATIONS: Gastrointestinal Spasm and Hypermotility

CONTRAINDICATIONS Pyloric obstruction, gastric retention, obstructive organic disease of the gastrointestinal tract, organic cardiospasm, duodenal stenosis, stenosing peptic ulcer, and urinary bladder neck obstruction or prostatic hypertrophy are contraindications to the use of this drug

WARNING Overdosage produces anticholinergic side effects. Although the animal reproduction studies are negative, until there is clinical confirmation of safety in pregnancy, this product should not be used in women who may become pregnant unless in the opinion of the physician the benefits outweigh the risks.

PRECAUTIONS. Use only with caution in patients with certain types of cardiovascular disease, since anticholinergic drugs may cause arrhythmias Extensive clinical studies of TREST have shown no evidence of glaucoma However, the possibility exists that it can occur since it has been reported as a characteristic side effect of anticholinergic drugs This product does not replace definitive treatment in organic gastrointestinal disease

SIDE EFFECTS Side effects are generally absent when TREST is used in the recommended dosage of 1 to 2 mg. three times daily Uncommonly, allergy or sensitivity to the drug may be manifested by generalized rash or widespread desquamation. In case of prolonged or massive overdosage, dry mouth, blurred vision, and urinary retention, typical side effects common to anticholinergic drugs, may occur Occasionally, sensitive patients may notice mild dryness of mouth or slight blurring of vision from doses of 2 mg or more Most patients tolerate single doses of 5 mg without such side effects

DOSAGE The usual adult dosage is 1 mg by mouth three times daily If necessary, the dose may be increased to 2 mg. three times daily Pediatric dosage has not been determined

CAUTION Federal law prohibits dispensing without prescription

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the many kindnesses and courtesies shown us during our visit to Louisville during the annual meeting of the Kentucky Medical Association. We had a most enjoyable time and will remember our visit with the KMA.

"The President's Luncheon on Wednesday noon with Doctor Judd was a very appropriate meeting and subject."

Kenneth O. Neumann, M.D.
President-Indiana State Medical Association
Lafayette, Indiana

"Thanks to all of your members and to your office staff who were very thoughtful and hospitable, on the occasion of my visit to your Annual Meeting.

"Charlie Bryant and Bob Pennington were excellent hosts."

Richard E. Flood, M.D.
President-West Virginia State Medical Association
Charleston, West Virginia

"It was indeed a pleasure to come to Louisville and talk to such an interested and attentive audience. May I also say that I feel that Louisville is an ideal convention city. The people were friendly and everyone was most helpful in making an outsider feel completely at home."

Howard H. Steel, M.D.
Dept. of Orthopedic Surgery
Temple University Medical Center
Philadelphia, Pa.

Committee Reports

KMA Committee on Medicine and Religion

Joseph H. Saunders, M.D., Lexington, Chairman

Kentucky Hotel, Louisville Wednesday, September 21, 1966

For the second straight year the KMA Committee on Medicine and Religion held a breakfast meeting during the KMA Annual Meeting. Activity at this meeting centered on the orientation of the newly appointed trustee district chairmen and organizational plans for the coming association year.

Guests at this meeting included Mr. Arne Larson, Assistant Director of the AMA Department of Medicine and Religion; Dr. David Steere, Director of Field Education and Professor of Pastoral Theology of the Presbyterian Theological Seminary in Louisville; The Reverend Mr. T. O. Harrison, Chaplain at the Good Samaritan Hospital in Lexington; Robert E. Pennington, M.D., KMA President; Leroy C. Hess, M.D., Eighth District Trustee; and all trustee district chairmen were invited to attend.

The committee also had an exhibit and conducted tape-recorded interviews at the Convention Center during the annual meeting.

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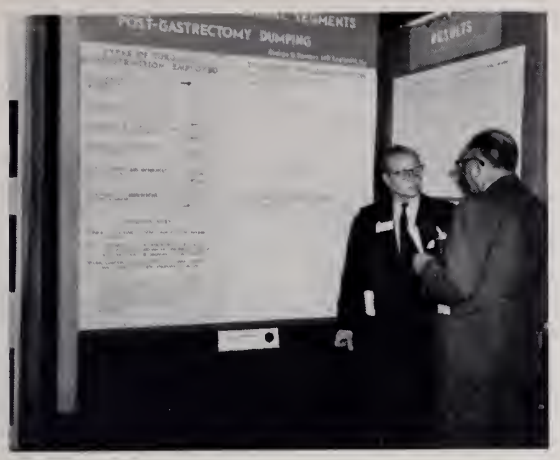
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Contact: Medical Director, Highland Hospital, Asheville, N.C. 28801



Pictured above is George B. Sanders, M.D., Louisville (on left) explaining his scientific exhibit to a fellow physician during the 1966 KMA Annual Meeting. Doctor Sander's exhibit, "The Use of Anti-peristatic Jejunal Segments to Relieve Post-Gastrectomy Dumping", was judged the outstanding scientific exhibit during the Annual Meeting and makes him the recipient of a cash award and the Aesculapius Award.

Public Health Page *(Continued from page 972)*

these Regulations. It establishes the emergency organization and administrative assignments of responsibilities and a staffing pattern clearly defining the line of succession necessary in an emergency.

A list of essential medical survival items along with the capability of the State to produce, substitute, and convert non-essential items, were formulated by the Committee. The essential medical survival items include:

1. Pharmaceuticals
2. Blood Collecting and Dispensing Supplies
3. Biologicals
4. Surgical Textiles
5. Emergency Surgical Instruments and Supplies
6. Laboratory Equipment and Supplies

The Health Task Group Committee held a series of meetings to develop this Plan culminated by a one-day test exercise which was presided over by the Governor of Kentucky. This exercise was held at the State Capitol on October 13, 1966 in conjunction with all departments within State Government. The purpose was to evaluate the ability of each department to function effectively during a national emergency through the employment of the Emergency Resources Management Plan. Additional meetings for the purpose of review and updating of the Plan will be held in the future.

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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. Side effects and **precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

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McCracken

The regular meeting of the McCracken County Medical Society was held at Boswell's Restaurant on September 28 with Walter Johnson, M. D., Paducah, president, presiding.

Due to a conflict in his schedule Ed Gall, M. D., professor and chairman of the department of pathology. University of Cincinnati, who was to be the guest speaker in the scientific portion of the meeting was unable to attend.

In answer to a request from Mrs. Edna C. Glenn, social worker, that local doctors be appointed to serve on the professional advisory council to the Western Kentucky Regional Mental Health and Mental Retardation Advisory Board, Doctor Johnson appointed four physicians to serve on this council representing the society. The physicians appointed are: Glenn Noss, M. D., William B. Haley, M. D., Winfield Stryker, M. D., and Frank B. Crawford, Jr., M. D.. all of Paducah.

A letter from the Western Baptist Hospital notified the society that the hospital continued to occupy the position of receiving applications for medical staff privileges from qualified physicians, regardless of race, color, creed, or national origin.

George H. Widener reported concerning the information he had on the insurance potential of the

The application of Richard Blair, M. D., for membership was accepted unanimously. He is in the practice of ob-gyn in association with Leon Higdon, M. D., Harold Priddle, M. D., and Charles Bohle, M. D.

James Harris, M. D., recently elected vice president of the KMA, reported on the KMA House of Delegates meeting. Doctor Haley, who was also a delegate, made comments.

Report of the meeting was submitted by Frank B. Crawford, Jr., M. D., secretary-treasurer.

KIMA To Meet Dec. 14

The Kentucky Industrial Medical Association will meet at 7:00 P.M., Wednesday, December 14, at Holiday Inn NE on Brownsboro Road in Louisville. Dinner is by reservation.

Robert Summer, M.D., Louisville, will be the guest speaker. For further information, please contact Albert S. Irving, M.D., 1028 Cherokee Road, Louisville.

Dr. Howard Honored in Louisville

C. C. Howard, M.D., Glasgow, past KMA president, is the recipient of the Annual Dearholt Award which was presented to him by the Mississippi Valley Thoracic (Chest) Society. The group honored Doctor Howard at its annual meeting in Louisville, the second week of October.

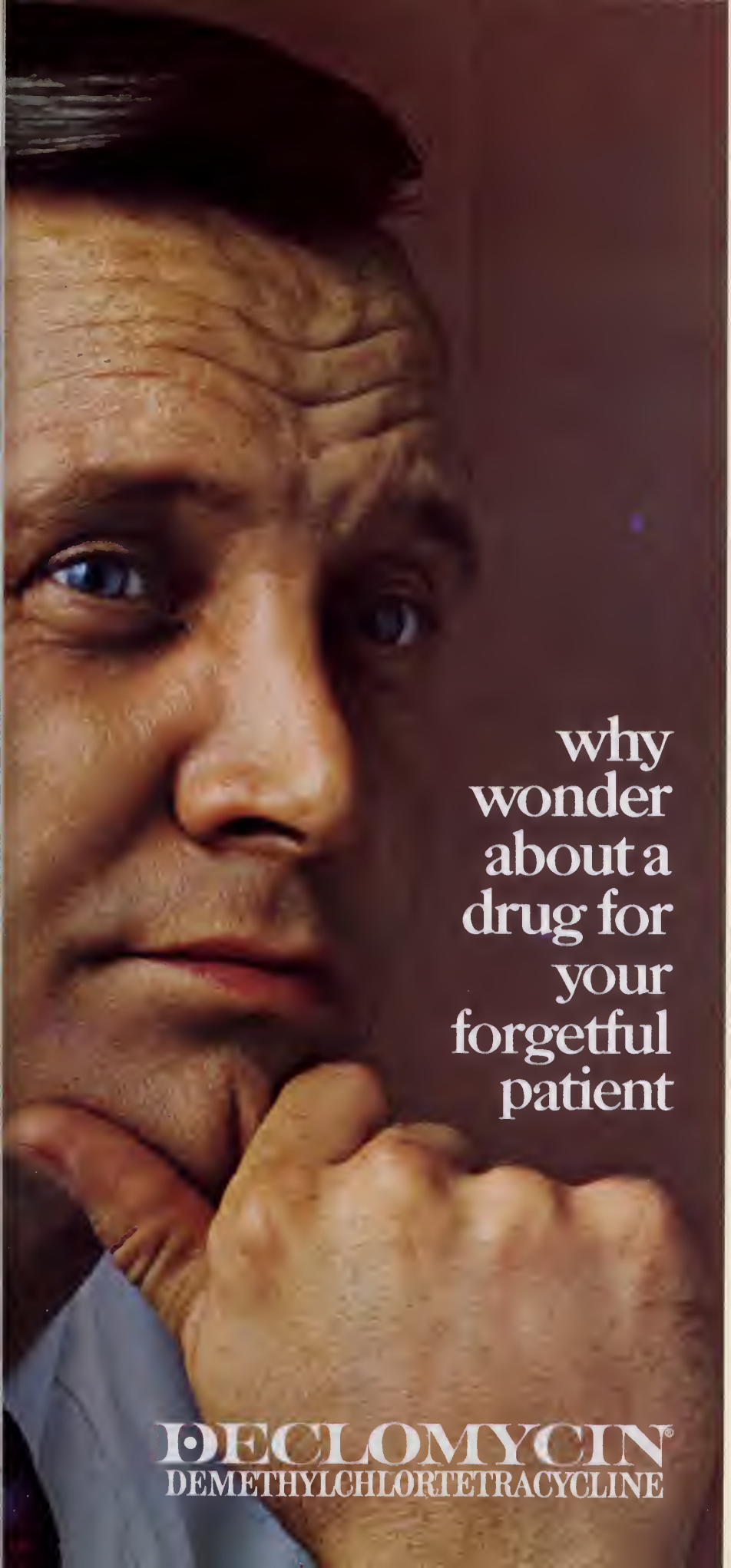


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Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

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1. Date of Filing: September 29, 1966.

2. Title of Publication: THE JOURNAL OF THE KENTUCKY MEDICAL ASSOCIATION.

3. Frequency of issue: Monthly.

4. Location of known office of publication: 3532 Janet Avenue, Louisville, Jefferson County, Kentucky 40205.

5. Location of the headquarters or general business offices of the publishers: Same as above.

6. Names and addresses of Publisher, Editor, and Managing Editor: Publisher—Kentucky Medical Association, 3532 Janet Avenue, Louisville, Ky., 40205. Editor—Walter S. Coe., M.D., 516 Heyburn Building, 332 West Broadway, Louisville, Ky., 40202. Managing Editor—J. P. Sanford, 3532 Janet Avenue, Louisville, Ky., 40205.

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10.

	Average No. copies each issue during preceding 12 months	Single issue nearest filing date
A. Total No. copies printed:	3073	3085
B. Paid circulation		
1. Sales through dealers and carriers, street vendors and counter sales:	62	62
2. Mail subscriptions:	2349	2349
C. Total paid circulation:	2411	2411
D. Free distribution including samples by mail, carrier, or other means:	450	460
E. Total distribution:	2861	2871
F. Office use, left-over, unaccounted, spoiled after printing:	212	214
G. Total:	3073	3085

I certify that the statements made by me above are correct and complete.

J. P. Sanford, Managing Editor

Andrievs J. Dzenitis, M.D., is now in practice in Louisville, in association with Thomas M. Marshall, M.D., limiting his practice to neurosurgery. Doctor Dzenitis graduated from the Indiana University School of Medicine in 1960. He was an intern at Methodist Hospital, Indianapolis, Indiana, until 1961, and he did his residency at the Indiana University Medical Center until 1966.

A 1965 graduate of the University of Kentucky College of Medicine, **Raymond D. Wells, M.D.,** has begun his general practice in Inez. Doctor Wells served his internship at the Nashville Baptist Hospital, Nashville, Tenn. during the year 1966.

C. M. Brand, M.D., Jeffersonville, Indiana, has entered practice in Frenchburg, Kentucky, in association with Donald Graves, M.D. Doctor Brand will do anesthesiology and general practice. He graduated from the University of Louisville School of Medicine in 1947. Doctor Brand completed his internship at Norfolk General Hospital in 1948, and his residency at the University of Louisville in 1952. Until his move to Frenchburg, Doctor Brand practiced in Lexington, Kentucky.

Mrs. Jack J. Martin, Tompkinsvilel, 1964-65 President of the Woman's Auxiliary to the Kentucky Medical Association, participated in a panel before the Woman's Auxiliary of the AMA at its Conference in Chicago, October 2-4. Mrs. Martin discussed the Rural Kentucky Medical Scholarship Fund and the Scholarship program of the Woman's Auxiliary to the AMA.

William P. Stone, Jr., M.D., has started practice in association with the Graves-Gilbert Clinic, Bowling Green, limiting his practice to internal medicine. Doctor Stone graduated from the Vanderbilt University School of Medicine in 1960. He completed his internship at the University of Mississippi Medical Center in 1961, and completed his residency at the University of Mississippi in 1963. Until coming to Kentucky he practiced in Jackson, Mississippi.

Nelson B. Rue, M.D., Bowling Green, has started practice with the Graves-Gilbert Clinic, limiting his practice to general surgery. Doctor Rue graduated from the University of Louisville School of Medicine in 1956. He completed his internship at St. Elizabeth Hospital in Dayton, Ohio, in 1957, and his residency at Louisville General Hospital in 1958. Until the present he has been stationed at the U.S. Air Force Hospital in New York City.

Robert D. Wilber, M.D. has begun his military service at Fort Knox, Ireland Army Hospital, working in internal medicine and gastroenterology. He graduated from University of Kansas Medical School in 1961. Doctor Wilber completed his internship at St. Luke's Hospital, Kansas City, Missouri, in 1962, and his residency at the Mayo Clinic in 1966, before coming to Fort Knox.

Richard A. Blair, M.D., a native of Meade County is now practicing in association with Doctors Higdon, Priddle, and Bohle, limiting his practice to obstetrics and gynecology. Doctor Blair graduated from the University of Louisville School of Medicine in 1959. He completed his internship at SS. Mary and Elizabeth Hospital in Louisville in 1961, his residency at St. Joseph's Infirmary in 1963, and his residency in obstetrics and gynecology at Louisville General Hospital in 1966.

Patrick J. Serey, Campton, Kentucky general practitioner, has started practicing in association with Paul F. Maddox, M.D. Doctor Serey graduated from the University of Louisville Medical School in 1964. He completed his internship and residency training at St. Vincent's Hospital, New York City, in 1966.

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NEWS ITEMS

Charles Terry, M.D., general practitioner, has gone into practice in Irvine. Doctor Terry graduated from Vanderbilt University School of Medicine in 1965 and he completed his internship at the University of Kentucky in 1966.

D. Vertrees Hollingsworth, M.D., general practitioner has gone into practice in Georgetown, in association with J. C. Cantrill, M.D., and R. K. Brown, M.D. Doctor Hollingsworth graduated from the University of Cincinnati College of Medicine in 1963, and he completed his internship at Receiving Hospital, in Detroit, Michigan, in 1964.

John P. Blackburn, M.D., Bowling Green, has gone into practice in association with Richard F. Grise, M.D., limiting his practice to general and thoracic surgery. Doctor Blackburn graduated from Vanderbilt University Medical School in 1958, and completed his internship at Vanderbilt in 1959. He completed his residency in general surgery at the University of Virginia in 1964, and completed his residency in Thoracic surgery at Lahey Clinic in Boston in 1966.

John M. Reed, M.D., Mayfield general practitioner, has moved to Florida where he is a resident in Radiology at the University of Florida. Doctor Reed graduated from the University of Louisville School of Medicine in 1960.

Joe A. Nichols, M.D. has recently become an associate in general practice of **H. Tod Smiser, M.D.** in Cynthiana. Doctor Nichols, a 1963 graduate of the University of Louisville School of Medicine, entered the U.S. Army in 1964, where he was stationed in Fairbanks, Alaska at Ft. Wainwright's Bassett Army Hospital. He interned at Floyd Hospital, Rome, Ga.

Wiley E. Kozee, M.D., has started practice in Ashland, limiting his practice to general psychiatry. He graduated from the University of Louisville School of Medicine in 1957. Doctor Kozee completed his internship at Spartanburg, South Carolina General Hospital in 1958, and he completed three years of residency in psychiatry at Rollman Psychiatric Clinic, Cincinnati, Ohio, and at the University of Kentucky Medical Center in 1961. He previously had a general practice in Catlettburg, Kentucky.

Robert Hyde, M.D., general practitioner, has started practice in Eddyville. He graduated from the University of Louisville School of Medicine in 1963. Doctor Hyde completed his internship at St. Elizabeth Hospital, Dayton, Ohio, in 1967. He was previously a physical therapist and worked for three years at the Rehabilitation Center in Louisville. Doctor Hyde practiced in Winchester, Kentucky before going to Eddyville.

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Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuharic, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

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Many medical organizations are setting dates for their winter and spring meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky., 40205.

IN KENTUCKY

DECEMBER

15	Norton Memorial Infirmary Annual Seminar, Norton's, Louisville

JANUARY

19	KAGP Northern Kentucky Seminar, Holiday Inn, Cincinnati South, So. Ft. Mitchell, Kentucky

IN SURROUNDING STATES

NOVEMBER

14-17	Southern Medical Association, Washington Hilton Hotel, Washington, D.C.
26-27	American College of Chest Physicians, Flamingo Hotel, Las Vegas
27	National Conference on the Medical Aspects of Spots, Caesar's Palace, Las Vegas
28-30	Radiological Society of North America, The Dunes, Las Vegas
27-Dec. 2	Radiological Society of North America, Palmer House, Chicago

DECEMBER

3-8	American Academy of Dermatology, American Hotel, Bal Harbour, Fla.
6-8	Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton, Fla.
8-10	Society for Cyro-Ophthalmology (1st. Annual Clinical Meeting), Dunes Hotel, Las Vegas

JANUARY

14-19	American Academy of Orthopaedic Surgeons, Civic Auditorium, San Francisco
23-25	Society of Thoracic Surgeons, Muehlback Hotel, Kansas City, Mo.
31-Feb. 4	American College of Radiology, Los Angeles

FEBRUARY

8-10	American Academy of Occupational Medicine, San Francisco Hilton Hotel, San Francisco
9-15	Congress on Medical Education, Palmer House, Chicago
15-19	American College of Cardiology, Washington Hilton Hotel, Washington, D.C.
26-March 4	American Society of Clinical Pathologists, Dunes Hotel, Las Vegas

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JOURNAL OF THE KMA BUYERS GUIDE FOR OCTOBER, 1966

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Warn against hazardous occupations requiring complete mental alertness. Use caution in administering to addiction-prone patients or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

Dosage: *Oral*—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

Supplied: Capsules, 5 mg, 10 mg and 25 mg—bottles of 50.



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DECEMBER 1966 • VOLUME 64 • NUMBER 12

Season's Greetings

THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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MAY 3 1967

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KMA 1967 Interim Meeting—April 19 and 20
Ken-Bar Inn, Gilbertsville

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References: (1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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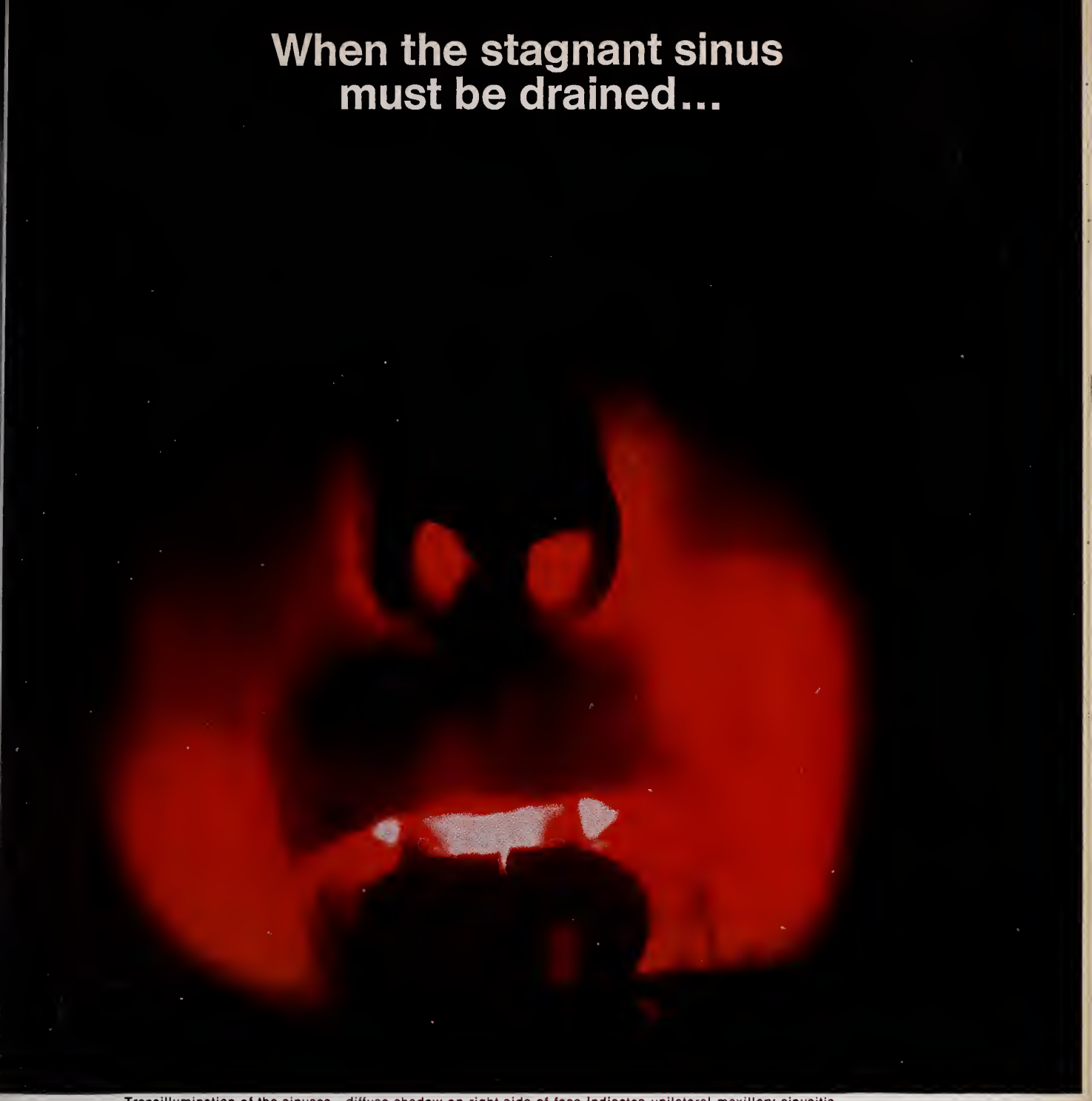
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1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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the
approach of the
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of our many blessings and take time
to renew old friendships and enjoy the
holidays with relatives and friends . . .
It is a time of prayer . . . meditation . . .
and hope for "Peace on Earth—Good-
will Toward Men". It is a time for rejoicing
and for contemplating the accomplish-
ments of the past and for looking forward
to the future. May your holidays be joyous and
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Greetings

Robert E. Pennington

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Contraindication—History of hypersensitivity to tetracycline.

Warning—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

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IN KENTUCKY

JANUARY

19	KAGP Northern Kentucky Seminar, Holiday Inn Cincinnati South, So. Ft. Mitchell, Kentucky

MARCH

15-17	Recent Advances in Pediatric Clinical Pathology, University of Kentucky Medical Center, Lexington
23-25	Fifth Annual Postgraduate Seminar for Pediatricians, University of Kentucky Medical Center, Lexington ($35.00 fee)

IN SURROUNDING STATES

JANUARY

12-14	Forensic Medicine: The Doctor and the Law, Mound Park Hospital Foundation, St. Petersburg, Fla.
14-19	American Academy of Orthopaedic Surgeons, Civic Auditorium. San Francisco
18-18	Cleveland Clinic Educational Foundation (Course in General Surgery), Bunts Auditorium-Educational Building, Cleveland, Ohio
23-25	Society of Thoracic Surgeons. Muehlback Hotel. Kansas City, Mo.
31-Feb. 4	American College of Surgeons, Los Angeles

FEBRUARY

1-2	Cleveland Clinic Educational Foundation (General Practice), Bunts Auditorium, Cleveland, Ohio
8-10	American Academy of Occupational Medicine, San Francisco Hilton Hotel, San Francisco
9-15	Congress on Medical Education, Palmer House, Chicago
15-19	American College of Cardiology, Washington Hilton Hotel, Washington, D.C.
23-25	American Academy of Pediatrics. Boston Lying-in-Hospital, Boston
26-March 4	American Society of Clinical Pathologists, Dunes Hotel, Las Vegas

MARCH

8-9	Cleveland Clinic Educational Foundation, "Advances in Urology", Bunts Auditorium, Cleveland, Ohio
9-11	American Academy of Pediatrics, University of Tennessee College of Medicine, Memphis
30-April 1	American Academy of Pediatrics, Stanford University School of Medicine, Palo Alto, Calif.

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The Department of Obstetrics and Gynecology of Duke University Medical Center, has announced the establishment of the Southeastern Regional Center for Trophoblastic Neoplasms, sponsored by a Service Health Project Grant Award from the Department of Health, Education, and Welfare (Division of Chronic Disease).

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Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

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†The need for these substances in human nutrition has not been established.

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Q. What is a "calendar year" for determining a benefit period?

A. The first calendar year benefit period begins July 1, 1966, or the effective date of the contract if it comes later than July 1, and ends December 31, 1966. Following calendar year benefit periods are from January the first to December the Thirty-first in each year.

Q. Is it true that the $100 deductible on Blue Cross-Blue Shield 65 "Extended Benefits" has been changed?

A. Blue Cross-Blue Shield Management has decided as a matter of policy at present to apply only a $50 deductible for the benefit of members. Continuation of this policy will depend on financial experience in the coming months.

Q. If my physician's bills and other eligible expenses between July 1, 1966, and December 31, 1966, do not exceed the $50 deductible required by Blue Cross-Blue Shield 65 "Extended Benefits," can these bills be applied to the next year's deductible?

A. Only those bills incurred in October, November, and December of any year may be applied to the next year's deductible.

Q. What are "eligible expenses" in the Extended Benefits portion of Blue Cross-Blue Shield 65 program?

A. In addition to physicians' charges and covered hospital charges, such items as: rental of wheel chair and other durable equipment used for medical treatment and orthopedic braces (except corrective shoes), crutches and prosthectic appliances such as artificial limbs and eyes.

Q. Will eligible charges for separate conditions be included in satisfying the $50 deductible?

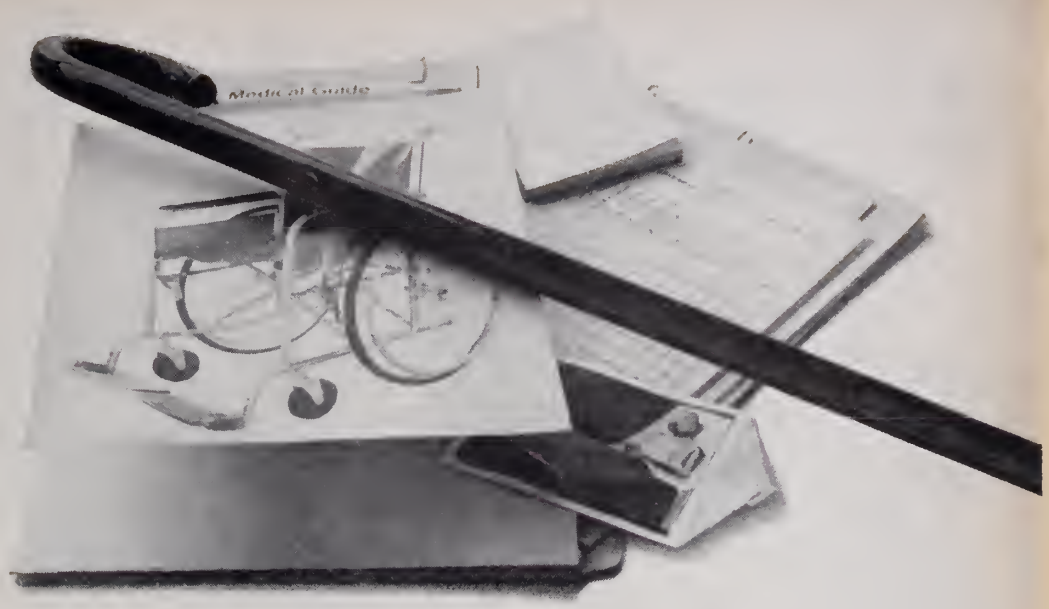
A. Yes.

Q. Are drugs and medications covered under Blue Cross-Blue Shield 65?

A. Only drugs administered in a hospital to a bed patient.

Q. Does Blue Cross-Blue Shield 65 pay for hearing aids and eyeglasses?

A. No, not for these items nor for examinations for them, nor for their repair.



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VOLUME 64 DECEMBER 1966 No. 12

Blue Dot Infection of the Scalp in Two Brothers†

ULLIN W. LEAVELL, JR., M.D.,* ELON B. TUCKER, M.A.,** and RUDOLPH MUELLING, M.D.***

Lexington, Kentucky

Two brothers were infected by blue dots of the scalp from which Penicillium species and Pullularia pullulans were isolated. Pure cultures of these organisms failed to produce the disease.

TWO brothers who had blue dots on their scalps from which Penicillium species and Pullularia Pullulans were isolated are reported. In the available literature, reports of a similar condition have not been found.

Fungal and bacterial infection related to disease in man is being reported more frequently especially as antibiotic, immunosuppressive, and radiomimetic drugs are being used more frequently, Keye[1], Huang[2], Thomas[3], Hale[4]. The pathogenic potential of Penicillium species has been pointed out by Rippon[5]. He states that the ability of a fungus to invade the deep organs of an animal is related in part to the potential of a morphologic transformation to a parasitic stage, often yeast-like. He showed that isolates of Penicillium were able in time to grow at increasing concentrations of cysteine on gradient tilt plates at 37° C with a concomitant morphologic alteration. The end result was an organism that readily invaded the deep tissue of animals and caused disease similar to that of the dimorphic fungi.

Penicillium has been isolated from many different lesions and organs. Penicillium was reported to attack the hair of the scalp and beard by Castellani[6]. Penicillium was isolated from the skin of the foot and ulcers of the toes by Mantelli[7] and Kesten[8]. It was isolated from cases of omychomycosis by Brumpt[9], Wile [10], and Weidman[11]. A case of otitis media with temporal lobe abscess was reported by Polyanskiy[12] from which penicillium was isolated. Cases of otomycosis from which penicillium were isolated were reported by Wolf[13] and Haley[14]. Pulmonary lesions from which penicillium was isolated were reported by Virchow[15], Telice[16], Vuillimin[17], Huang[2], Link[18], and Giodono[19]. Lesions of the brain from which penicillium was isolated were reported by Huang[2]. Penicillium was isolated from cases of genito-urinary track involvement by Gilliam[20], Chute[21], and Salisberry[22].

Pullularia pullulans has been isolated from cases of cutaneous involvement. It was isolated

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****Department of Pathology, University of Kentucky Medical Center.*

from a case with darkly pigmented crusted lesions on the chest, arms, and legs by Low[23]. Haley[24] isolated Pullularia pullulans from a case of otomycosis.

Lesions of many different colors have been reported from which penicillium has been isolated. Blue and blue-green fungi were reported upon the skin and lungs of swans by Jager[25], stork by Hensingeo[26], crows by Threle[27], flamingo by Owen[28], goose by Endes[29], chicken and deer by Serrurier[30], and snow owl by Muller[31]. Castellani[6] reported green, gray and black nodules of the beard and moustache. Mantelli[7] found black grains in the interior of a lesion of the foot. Virchow[15] found greenish gray areas in the lungs of four autopsy cases. Gilliam[20] reported a bolus of pink material in the urine. Chute[21] reported little white masses in the urine. Flores[32] reported grayish violet pinta.

Weidman[11] reported round double wall spores on a potassium hydroxide scraping from a case of onychomycosis associated with Penicillium brevicaule. He compared the appearance of the spores with those of blastomycosis.

Report of a Case

The patient was a 10 year old white dentist's son who had had blue dots on his scalp for 24 months. His 8 year old brother had had the same difficulty for two months. The brother's activities had been similar for the past 4 to 5 years.

The eruption started 24 months ago when the patient lived in another city. It occurred about one month after he had been bathing in a public park wading pool. His father was with the Department of Recreation at that time. He had a severe eye infection coincident with the onset of the scalp problem, which necessitated his seeing an eye specialist five or six times.

The family moved to another city 18 months ago. The infection of the scalp persisted. The patient was treated by another physician 12 months ago. He was given a "fungus pill" for 3 weeks and selenium sulfide shampoo without improvement. The lesions were removed by shampooing, but recurred in four or five days. There had been no symptoms. The patient went to picture shows once a week. He used a plastic comb and brush which was washed every three or four weeks. He used a towel to dry his scalp. He usually kept his hair cut very short.

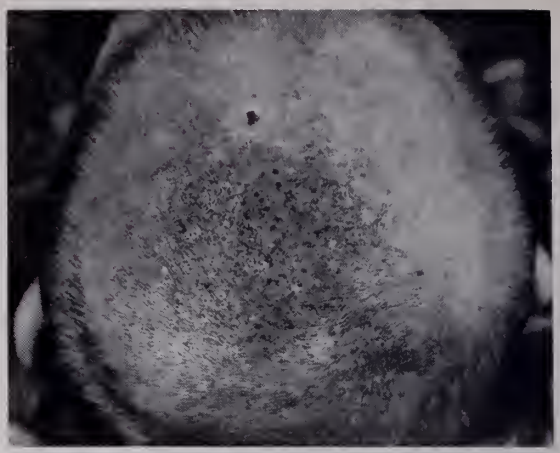


Fig. 1. The arrow points to light blue dots scattered over the vertex of the scalp. The black soot-like areas may be seen surrounding the blue dots.

Physical Examination revealed 40 to 50 blue dots over the vertex of the scalp which measured 0.1 to 0.4 cm. in diameter, Fig. 1. Underlying the blue dots was a layer of what appeared to be black soot. The area involved measured about 10 cm. in diameter and was on the vertex of the scalp. The blue dots and black material were removed by scraping with a scalpel and cleaning with benzalkonium chloride sponges. The hairs broke easily although there was no detectable alopecia. The blue dots lay between the follicles, none were seen on the hair. The black soot appeared to extend into the hair.

Laboratory data: Six potassium hydroxide scrapings showed mycelia and many round, double walled, budding spores. The organisms were seen in abundance throughout the preparation, Fig. 2. Occasional double wall, brown spores were seen in clumps and chains, Fig. 3.

The biopsy, stained with hematoxylin and eosin, showed round, double wall spores in the keratin layer similar to those seen on potassium hydroxide scrapings. Double wall, brown spores were seen which were similar in appearance to those seen on potassium hydroxide scrapings. Four nests composed of ten to twelve spores were present in the upper epidermis. A periodic acid Schiff stain showed oval, budding organisms and round budding organisms.

Four cultures of blue dots and black soot on Sabouraud's medium grew Penicillium species and Pullularia pullulans, Fig. 4.

No growth on Sabouraud's medium was noted with sputum, urine, stool, drinking water,

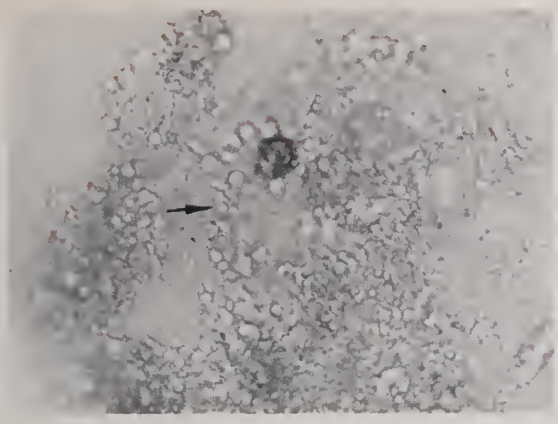


Fig. 2. Many double wall round spores are seen in a potassium hydroxide scraping from the blue dots. The arrow points to a budding organism.

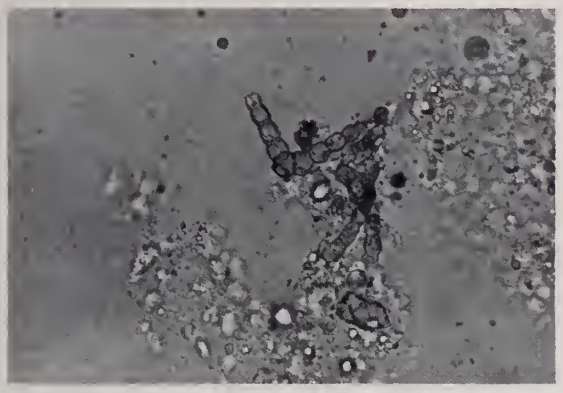


Fig. 3. Brown spores in chains and clumps are seen in a potassium hydroxide scraping from the black soot-like areas.

soap, shampoo, yard dirt, pencil, crayon, or fingernail cultures. Six Sabouraud's medium plates were exposed for two hours to air in six different rooms in the patient's house. Penicillium species were cultured from each of these cultures.

Four mice were inoculated intraperitoneally with 0.5 cc. of 0.1% saline suspensions of blue dots and black soot. No lesions were found when they were sacrificed one week and six weeks later and no organisms were grown on Sabouraud's medium or blood agar from peritoneal scrapings. The skins of two guinea pigs and two rabbits were shaved. Two blue dots were transferred from the patient and rubbed onto the skins of the rabbits and guinea pigs. No growth occurred after four weeks. Two blue dots were vaccinated by multiple puncture

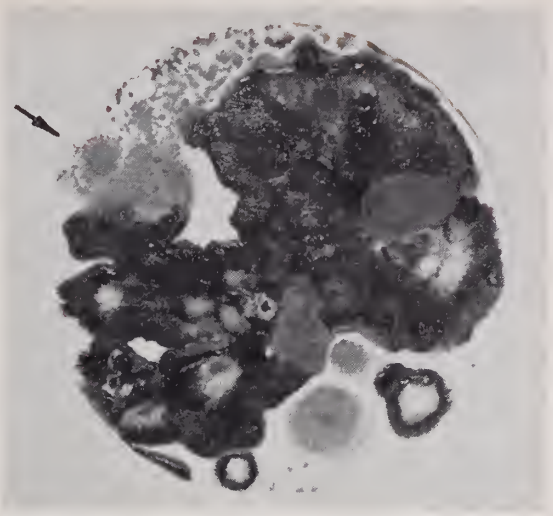


Fig. 4. Two different types of growth may be seen on a Sabouraud's media plate at room temperature. The arrow points to the blue Penicillium species. The black culture in the remainder of the plate is Pullularia pullulans. 1963; reproduced with the permission of the publishers.)

into the skins of the two rabbits and two guinea pigs. There was no growth after four weeks. The same procedure was carried out with the black soot areas and no growth occurred.

The chest x-ray was normal.

Course: The black areas were very apparent when the skin was cleaned in preparation for a biopsy. Four wet benzalkonium chloride sponges were necessary to remove the black material from the skin.

Two areas 4.0 cm. in diameter were cleaned with benzalkonium chloride and an occlusive dressing was applied to the entire scalp. The occlusive dressing was removed one week later. The blue dots and black areas had reappeared in the areas previously cleaned. Blue dots were seen in large numbers over the sides of the scalp. Blue dots and black soot were applied to the left forearm and covered with an occlusive dressing for one week. There was no growth of either blue dots or soot-like areas at the end of one week.

There was no treatment as we wanted to study the natural course of the disease. Six months after the patient was first seen the numbers of blue dots had decreased and he only had 6 or 8 lesions. The black soot areas had also decreased by an estimated ninety per cent.

Acceptance of a causal relationship between the blue dots and soot areas and Penicillium species and Pullularia pullulans should await further reports of similar cases of fulfillment of Koch's postulates.

Comment

A previously unreported fungal disease manifested by blue dots of the scalp overlying black soot areas in two brothers is presented.

The following evidence from the literature supports a causal relationship between penicillium species and Pullularia pullulans and blue dots and black soot areas on the scalp of our patient. Penicillium species has been isolated from many organs and may manifest itself clinically with different colors. Pullularia pullulans has been isolated from darkly pigmented crusted lesions of the skin. Penicillium has been shown to have pathogenic potential in a yeast phase.

The following evidence from our case supports a causal relationship between Penicillium species and Pullularia pullulans and blue dots and black soot. The disease recurred under an occlusive dressing. Two different spores and mycelia were seen on six potassium hydroxide scrapings. The double wall, round spores were similar to those reported by Weidman[11]. He reported a case of onychomycosis from which penicillium brevicaule was isolated. Two different spores were seen in tissue stained with hematoxylin and eosin and periodic acid Schiff stains. Nests of spores were present in the superficial part of the epidermis just beneath the stratum corneum. Dividing spores were seen on potassium hydroxide scrapings and tissue stained with hematoxylin and eosin and periodic acid Schiff stains. Penicillium species and Pullularis pullulans were isolated on four different occasions on Sabouraud's medium.

Species identification of the Penicillium was not done. The term ceruleomycosis could be applied to similar conditions in the future.

Addendum: Since this article was written Drs. E. P. Cawley and P. E. Weary of the University of Virginia Medical School, Charlottesville, Va., told me of a family of three children that they had recently seen with blue dots of the scalp.

Generic and Trade Names of Drugs

Selenium Sulfide—Selsun
Benzalkonium chloride—Zephiran

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Mark Your Calendar . . .

April 19 - 20

KMA Interim Meeting

Ken-Bar Inn, Gilbertsville

Surgery of Venous Stasis Ulcers†

Giles L. Stephens, M.D.*

Harold Faulconer M.D.**

Extra-fascial ligation of incompetent perforator veins is recommended when the patient first presents with the pathognomonic "ankle flare."

Subfascial ligation is recommended when the patient presents with a venous stasis ulcer.

THE PURPOSE of this study was to determine the beneficial effect of ligation of incompetent perforator veins in the treatment of venous stasis ulcers.

Our interest in the ligation of incompetent perforator veins increased considerably with the publication of F. B. Cockett's article "The Pathology and Treatment of Venous Ulcers of the Leg" in 1955.[2] We were particularly interested in determining the relative merits of the subfascial compared to the extrafascial ligation of these ankle perforator veins.

Material

Twenty-five patients having either an extrafascial or subfascial ligation of ankle perforator veins formed our material for clinical study. The longitudinal incision was made one finger breadth posterior to the medial border of the tibia as advocated by Cockett. The perforator veins were either ligated extrafascially or subfascially and no fascia was excised.

Findings

The average age of our patients was 50.6 years. There were four negro patients and twenty-one white patients which is in keeping with the hospital population ratio at this particular Veterans Administration Hospital. Eight right lower extremities and seventeen left lower extremities were involved in this clinical study. The duration of venous ulcerative disease in our patients averaged 6.2 years prior to ligation of the perforator veins.

In ten patients who had a subfascial ligation there was an in-hospital postoperative complication rate of zero per cent; however, in fifteen patients having an extrafascial ligation there was a 20 per cent incidence of in-hospital postoperative complication. One was an infection, one was a forty per cent failure of take of a skin graft, and a third was subtotal healing.

Long term follow up was obtained on 21 of these 25 patients (84%). Of 12 patients followed after an extrafascial ligation, seven had a recurrent ulcer. This represented a failure rate of 58.1 per cent. Of nine patients followed after a subfascial ligation there was a recurrence in 2 patients or 22.2 per cent. These rates of recurrent ulcer were based on long term follow up, the average length of which was 5.6 years. On a long term follow up evaluation of leg swelling, fifteen patients gave a definite answer to this question and thirteen stated they had persisent swelling of their leg. Of these thirteen patients with chronic leg edema six did not have a recurrent venous statis ulcer and seven did. Twelve of these thirteen patients were wearing an Ace bandage to control their leg edema.

Discussion

F. B. Cockett states that he has been reluctant to operate on any patient over the fifty to sixty year age group and most of his investigations and operations were carried out on patients younger than age fifty.[2] The average age of our patients was 50.6 years and some of these patients may have had subclinical arteriosclerosis. The thrombophlebitic involvement of eighteen left lower extremities compared to eight right lower extremities is in keeping with

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**Clinical Instructor in Surgery, University of Louisville School of Medicine; Attending Surgeon, Louisville Veterans Administration Hospital.*

***Fellow in cardiovascular surgery, University of Louisville School of Medicine.*

the experience of the Mayo Clinic. In their studies of postoperative thrombophlebitis the incidence was twice as common in the left lower extremity as in the right. There were 249 right lower extremities compared to 498 left lower extremities involved with thrombophlebitis in their series.[1] Cockett states that ulcers are amenable to surgical treatment with the reasonable hope of permanent cure only at a relatively early stage of their natural history. He states that the real place of the Cockett procedure is in the relatively early case. The duration of venous ulcerative disease is extremely important and in our series of patients this averaged 6.2 years. This length of time dramatically demonstrates the prolonged period of non-operative treatment prior to definitive surgery. Needless to say a marked amount of soft tissue destruction with fibrosis and impaired small artery blood supply as well as venous insufficiency in the ulcer bearing area has progressed in this long time interval to compromise the beneficial effects of definitive surgery. We feel that the high recurrence rate of venous ulcers in patients who have had prior vein surgery was due in the majority of cases to the prolonged period of uncontrolled venous hypertension with its known sequelae. We believe that the operative trauma of high ligation, stripping, and excision of the long saphenous varicosities was not a major etiological factor.

We were also interested in the comparison of our results in the patients who had extrafascial ligation compared to subfascial ligation of these perforator veins. Linton has advocated subfascial ligation. Cockett has advocated extrafascial ligation of these perforator veins where there was minimal soft tissue damage and subfascial ligation where there was considerable fibrosis in the ulcer bearing area.[4] Cockett reported a 20% incidence of minor skin edge necrosis.[2] Felder and Bernstein utilizing a posterior subfascial approach reported a small skin edge slough in 20% of sixty patients.[5]

Cockett reported 96 cases that had ligation of incompetent perforator veins with no recurrence of ulcer two years after surgery and he stated that cure of ulcers should be judged on the basis of a follow up of at least three to four years.[2] Felder and Bernstein reported 13 recurrent ulcers in 60 patients having a posterior subfascial ligation. Their average follow up was only 20 months.[5]

Moyer has stated that if the chronic edema is not controlled there is all likelihood that there will be a recurrence of the venous ulcer. Moyer states that the key to the treatment of the post-thrombophlebitic syndrome is control of the edema and that no operation can be expected to result in success if this factor is forgotten. In his experience it was only an exceptionally good result which did not require the permanent use of an elastic stocking.[7] In Moyer's study the recurrent ulcers formed at the periphery of the skin grafted area and it was his feeling that an inadequate amount of diseased skin and subcutaneous tissue was excised at the time of the skin grafting. Linton has since demonstrated that if the incompetent veins are removed the grafted area will stay healed despite the scar tissue.[6] Of thirteen of our patients on long term follow up, who had chronic edema, six did not have a recurrent venous ulcer and seven did. Twelve of these thirteen patients were using an Ace bandage to control their leg edema. Cranley et al reported a 13% incidence of recurrent ulcer following ligation of perforator veins and stripping of the long and short saphenous veins.[3] Our recurrence rate following the extrafascial ligation has influenced us to recommend the extrafascial ligation only in those patients who have never had a venous stasis ulcer and who present with the venous star with minimal soft tissue changes. In those patients with the post-thrombophlebitic syndrome who have never had a venous stasis ulcer and who have considerable to marked skin and subcutaneous fibrosis, we would recommend leg length elastic stocking support and no surgery. All patients with a venous stasis ulcer or past history of venous stasis ulcer that is temporarily healed, we believe should have a subfascial ligation of the incompetent perforator veins. It should be mentioned that the lateral ankle perforator vein may be the incompetent one, even though the ankle blowout is on the medial aspect of the ankle. In Cockett's series 12% had a lateral ankle perforator vein that was responsible for the ulcer which was primarily on the medial side of the leg.[2]

Conclusions

On the basis of our relatively discouraging long term follow up results with ligation of incompetent ankle perforator veins in the treatment of venous stasis ulcers, the authors would recommend early extrafascial ligation of these incompetent perforator veins when the patient first presents with the ankle flare or venous star. Those patients that present with a venous stasis ulcer should have a subfascial ligation with or without skin grafting after the edema is controlled. In all probability the majority of these patients should wear a well fitted elastic stocking with a closed heel for a period of years after their definitive surgery. Only when the edema fails to reappear should elastic support be discontinued.

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Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater leadership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

SPECIAL ARTICLES

Our President-Elect Writes From Vietnam*

Dear People:

The tourist bureaus, which advertise that the monsoon season is over by October, are like the Los Angeles Chamber of Commerce. This is the wettest drouth ever.

Have very decent quarters where four physicians and one hospital administrator run a private mess, living mostly on the local economy. The cook is a Vietnamese who probably deserves the title of *chef*. Food is edible, but rather heavy on sea-food and garlic for my taste.

The war in the delta makes little news in the state-side papers, but it is on. It is a continuing series of small, but quite vicious, operations. Produces considerable attrition, including American.

For me, this trip is a direct antithesis to the primitive lonesome pioneering of last year. Can Tho Medical Center is short on chromeplate, and the ceramic tile is unglazed, but the operation is strictly first-team, U.S. style.

The Air Force Surgical Team, which has been here for seven months, has two young surgeons who have just finished excellent residencies. The two civilian surgeons, here like me for two months, are also well-trained and obviously outstanding in their home communities.

The primary mission of the Americans here is the care of Vietnamese civilian war casualties. These come in at a rate of up to 25 major operations a day. When a big load shows up, all hands and the cook turn to. I have even scrubbed a few times to hold retractors and snip sutures, trying to remember what I learned in WW II.

To further increase casualty capability, we have three surgical technicians, developed by re-training aircraft mechanics. After three months training, they are scrubbing, circulating and repairing lacerations with dexterity and speed.

We also have, on a part-time basis, the services of three Army Medical Officers from nearby U.S. troops. They are fresh from internship, completing their military obligation. One of them is supposed to keep Pediatrics (with which this country is crawling) off my back, but it is hard to keep him out of the Operating Room.

Trying to keep his section on Medicine up with the "gung ho" Section on Surgery keeps the old Kentucky doctor well stimulated. As dengue, diptheria, malaria and typhoid endemic, every acute febrile disease is a brief post-graduate course in Tropical Medicine. Not all of the illnesses are exotic—I was pleased to pick a (proven) hydrops of the gallbladder with stone from the continuing stream of tropical hepatics and cirrhotics.

Bird-dogging for the surgeons is another source of stimulation. After warming up on decortication and lobectomies, they are wanting a patient for a pneumonectomy. They are also wanting a suitable case for a mitral commissurotomy, to initiate elective cardiac surgery in this country. It will have to be an uncomplicated case, for a closed procedure, as we do not have a pump (and haven't been able to get the aeroplane mechanics to make us one yet).

All in all, I have been so busy professionally, that there has been no time for picnics in the jungle so far.

GEORGE F. BROCKMAN, M.D.

**George F. Brockman, M.D., Greenville, sent the following letter too late for the November Journal. It was written during his second tour of duty as an American civilian physician working with the AMA Volunteer Physician Program.*

EDITORIALS

The Christmas Season

AS the year nineteen hundred and sixty-six comes to a close the Editors of the Journal take the opportunity to thank the many people who make the Journal possible. We thank the advertisers who patronize the Journal and we are grateful that their numbers continue to grow. Our thanks goes to the State Medical Journals Advertising Bureau which handles the business of our advertising for us. It is a pleasure to work with our printers, the Gibbs-Inman company, who, as always, are helpful and cooperative.

The Editors express their appreciation to the many physicians who as a manifestation of their interest in the Kentucky Medical Association make written contributions to the pages of the Kentucky Medical Journal. These contributions make the Journal the important historical documentary of Kentucky Medicine which it is.

During this year of nineteen hundred and sixty-six medical facilities within the state have continued to improve and to increase in number. Improved and new roads continue to make medical care more accesible to more people. Nineteen hundred and sixty-seven promises to make important additions in all of these areas. It is likely that during this past year the people in the state had in general the best medical care in the history of Kentucky, but there is to be no status quo in medicine and the present but lays the foundation for the future. The many unknowns that face those in medical research staggers the imagination. Socio-economic techniques for providing medical care challenge our medical leaders. The practicing physician is faced with the constant changes in medical knowledge and techniques. All of these circumstances promise to make nineteen hundred and sixty-seven a challenging, stimulating and busy year for the physicians of Kentucky.

WALTER S. COE, M.D.

The New President

ONE of the highlights of the recent annual meeting of the Kentucky Medical Association was the introduction of the new president, Robert E. Pennington, M.D., of London, Kentucky. Doctor Pennington succeeds Everett Baker, M.D., of Louisville who provided the Association with a year of effective and able leadership. Doctor Pennington has been an active participant in the affairs of the Association for a number of years and has come to know many of its members by reason of direct contact; other members have not had the opportunity of coming to know the new president.

Robert E. Pennington was born and reared in London, Kentucky. His father was a pioneer surgeon in Eastern Kentucky and was accustomed to covering a good portion of the mountain area on horseback and during the early days of his practice would operate in mountain homes on tables and on doors placed

across wooden horses. Robert Pennington's father built one of the first hospitals in Eastern Kentucky and practiced up until his death in 1944.

The Association's new President received a Bachelor of Arts and Masters degree from the University of Kentucky and Doctor of Medicine degree from the University of Pennsylvania. Followig an internship at the Philadelphia General Hospital and a period of time in Pathology at Western Reserve University, he became a Fellow in Surgery at the Mayo Clinic. During World War II Doctor Pennington, among other assignments, was commanding officer of the 47th Portable Surgical Hospital which was assigned to the China Theater to assist the Chinese Nationalist Army in their fighting on the Burma Front.

After discharge from the Army, Robert Pennington, began the practice of surgery in London, Kentucky. He has not been one to have many formal hobbies but he did enjoy playing golf until he became so involved in medical organizational affairs that the golf has been crowded out of his busy schedule.

The new President of the Association would like to have its members become more aware of the tremendous amount of work the Kentucky Medical Association carries on in the various fields of medicine and public relations. The work of the organization goes on because of the dedication and sacrifice of some of its members but Doctor Pennington feels that not enough of the members allow themselves to become involved in the many responsibilities of the Association. Another one of the new President's special interests is the possibility of developing some kind of code of understanding between physicians and attorneys. He has in mind a code in which grievances or complaints of patients are brought before Committees of attorneys and physicians and if there are no grounds for suit these complaints are dropped without suits being instituted accompanied with the associated publicity. He is also particularly interested in a study of the efficiency and economy of the Kentucky Medical Association's work and efforts in this direction have already begun.

Robert E. Pennington promises to provide the Kentucky Medical Association with informed, able and dedicated leadership during the year of his Presidency.

WALTER S. COE, M.D.

Wishing You All the

Joys of the Holiday Season

Walter S. Coe, M.D., Editor

and

The Journal Staff

*ABIDE WITH ME**

Henry F. Lyte

Abide with me: fast falls the eventide;
The darkness deepens; Lord, with me abide!
When other helpers fail, and comforts flee,
Help of the helpless, O abide with me.

Swift to its close ebbs out life's little day;
Earth's joys grow dim, its glories pass away;
Change and decay in all around I see;
O Thou, who changest not, abide with me.

I need Thy presence every passing hour,
What but Thy grace can foil the tempter's power?
Who, like Thyself, my guide and stay can be?
Thro' cloud and sunshine, Lord, abide with me.

I fear no foe, with Thee at hand to bless.
Ills have no weight, and tears no bitterness.
Where is death's sting? where, grave, thy victory?
I triumph still, if Thou abide with me.

Hold Thou Thy cross before my closing eyes;
Shine through the gloom and point me to the skies;
Heaven's morning breaks, and earth's vain shadows flee;
In life, in death, O Lord, abide with me.

**This tribute is printed in memory of the 58 Kentucky physicians passed away during the past year. See following page for complete list.*

Deceased Kentucky Physicians

1966*

James W. Archer, M.D., Paintsville
Lytle Atherton, M.D., Louisville
William P. Banta, M.D., Louisville
James Ross Bennett, M.D., Louisville
George Bradley, M.D., Elizabethtown
K. W. Brumback, M.D., Cynthiana
Leonard Champion, M.D., Lola
Grover C. Chostner, M.D., Louisville
B. J. Cockrell, M.D., Louisville
John E. Crawford, M.D., Whitesburg
Chester B. Creech, M.D., Middlesburg
Mack Dempsey, M.D., Wayland
Candor G. Depp, M.D., Hiseville
Katharine Dodd, M.D., Louisville
John M. English, M.D., Elizabethtown
Woodruff J. Flowers, M.D., Columbia
John B. Floyd, M.D., Lexington
William B. Foreman, M.D., Louisville
Oscar W. Frickman, M.D., Newport
J. Henry Fust, M.D., Louisville
Alphonso F. Guiglia, M.D., Louisville
William M. Hammack, M.D., Madisonville
William J. Hockaday, Jr., M.D., Madisonville
Edward C. Humphrey, M.D., Lexington
George F. Jones, M.D., Henderson
Tracy Jones, M.D., Harlan
Henry V. Johnson, M.D., Georgetown
Lowell R. Johnson, M.D., Louisville
Charles W. Justice, M.D., Ludlow
Paul E. Kerkow, M.D., Covington
Preston O. Lewis, M.D., Evarts
Clarence H. Likins, M.D., Louisville
Carl A. Marquardt, M.D., Augusta
William J. Martin, M.D., Russellville
John W. McGowan, M.D., Lexington
William R. McMillen, M.D., Covington
Cecil C. Merritt, M.D., Tollesboro
Carlisle Morse, M.D., Louisville
Carl Norfleet, M.D., Somerset
Holst V. Nyce, Perry County
Fred Ray, M.D., Independence
William D. Reddish, M.D., Lexington
James B. Rodgers, M.D., Louisville
John O. Salyers, M.D., Louisville
James P. Scott, M.D., Ashland
W. G. Shacklette, M.D., Valley Station
Robert C. Sievers, M.D., Somerset
E. R. Smith, M.D., Somerset
Thomas J. Snider, M.D., Taylorsville
John A. Snowden, M.D., Winchester
Lillian H. South, M.D., Louisville
John W. Taylor, M.D., Stamping Ground
Neal E. Taylor, M.D., Newport
Dillard D. Turner, M.D., Frankfort
Charles W. Wheeler, M.D., Louisville
Joe M. Withers, M.D., Cynthiana
Charles F. Wood, M.D., Louisville
Emery J. Yelton, M.D., Germantown

**List of names of deceased physicians available to The Journal as of November 20, 1966.*

The Joseph Potts Thomas Memorial Meeting
The Kentucky Medical Association

Terrace Room, Kentucky Hotel, Louisville, Kentucky, September 19-22, 1966

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

George F. Brockman, M.D., Greenville

Speaker of the House, Presiding

First Session

Doctor Brockman called the meeting to order and asked Joseph H. Saunders, M.D., Lexington, chairman of the KMA Committee on Medicine and Religion, to give the invocation. Donn L. Smith, M.D., Louisville, chairman of the Credentials Committee, reported that a quorum was present. A motion was made and seconded to accept the minutes of the 1965 session of the House of Delegates as published in the December 1965 issue of The Journal of the Kentucky Medical Association. The motion carried.

Henry B. Asman, M.D., KMA secretary, presented the general announcements. The Secretary reported that the President's Luncheon speaker would be Walter H. Judd, M.D., Washington, D.C. Doctor Asman pointed out that the seven reference committees would convene for their sessions at 2:00 p.m., Monday, on the mezzanine floor of the Kentucky Hotel. The opening scientific session was to begin on Tuesday, September 20, at 8:50 a.m., in the Convention Center.

The Secretary read the list of physicians who had passed away since the 1965 meeting and the members of the House of Delegates stood for a moment of silence. The names of the physicians, their locations and dates of death are as follows:

Archer, James W. (Member)	Paintsville	June 1966
Atherton, Lytle (Member)	Louisville	May 8, 1966
Banta, William P.	Louisville (In Calif.)	April 8, 1966
Bennett, James Ross	Louisville	Feb. 12, 1966
Champion, Leonard	Lola	Sept. 17, 1965
Cockrell, B. J.	Louisville	Mar. 27, 1966
Chostner, Grover C.	Louisville	Sept. 30, 1965
Crawford, John E.	Whitesburg	Dec. 29, 1965
Creech, Chester B.	Middlesburg	Oct. 1, 1965
Dempsey, Mark (Emeritus)	Wayland	June 5, 1966
Depp, Candor G. (Emeritus)	Hiseville	Oct. 17, 1965
Dodd, Katharine	Louisville	Nov. 7, 1965
English, John M.	Elizabethtown	April 16, 1966
Floyd, John B. (Emeritus)	Lexington	Mar. 10, 1966
Foreman, William B. (Emeritus)	Louisville	Nov. 17, 1965
Frickman, Oscar W.	Newport	Feb. 5, 1966
Fust, J. Henry	Louisville	Feb. 2, 1966
Hammack, William M. (Emeritus)	Madisonville	Dec. 1, 1965
Hockaday, William J. Jr., (Member)	Anchorage	Nov. 17, 1965
Humphrey, Edw. C.	Lexington	Jan. 27, 1966
Jones, Tracy	Harlan (Out of State)	Aug. 1966
Johnson, Lowell R.	Louisville	Jan. 30, 1966
Justice, Charles W. (Member)	Ludlow	Sept. 15, 1965
Kerkow, Paul E. (Emeritus)	Covington	July 11, 1966
Lewis, Preston O. (Emeritus)	Evarts	Oct. 10, 1965
Likins, Clarence H. (Emeritus)	Louisville	Feb. 15, 1966
Marquardt, Carl A. (Member)	Augusta	Feb. 11, 1966
Martin, William J.	Russellville	Dec. 10, 1965
McGowan, John W. (Member)	Lexington	Oct. 31, 1965
Merritt, Cecil C. (Emeritus)	Tollesboro	Mar. 9, 1966
Morse, Carlisle (Member)	Louisville	Oct. 30, 1965
Nyce, Holst W.	Perry County	Oct. 20, 1965
Ray, Fred	Independence	Sept. 26, 1965
Reddish, William D. (Emeritus)	Lexington	Oct. 7, 1965

**Editorial Note: A tape recording was made of the two sessions of the House of Delegates, and any member who desires to examine the transcript of the proceedings, may come to the headquarters office and listen to the recording.*

Rogers, James B. (Member)	Louisville	Nov. 19, 1965
Scott, James P. (Member)	Ashland	Sept. 28, 1965
Shacklette, W. G.	Valley Station	Nov. 11, 1965
Sievers, Robert C. (Emeritus)	Somerset	March 5, 1966
Snider, Thomas J.	Taylorsville	Feb. 15, 1966
Snowden, John A.	Winchester	Feb. 17, 1966
Stovall, J. Watts	Grayson	July 1966
Taylor, John W. (Emeritus)	Stamping Ground	May 9, 1966
Turner, Dillard D.	Frankfort	July 14, 1966
Wheeler, Charles W.	Louisville	Jan. 9, 1966
Withers, Joe M. (Member)	Cynthiana	July 1966
Wood, Charles F.	Louisville	April 29, 1966

The speaker announced the reference committee appointments as follows:

Reference Committee No. 1—Reports of Officers and Board of Trustees

Thomson R. Bryant, Jr., M.D., Lexington, Chairman
C. Melvin Bernhard, M.D., Louisville
Thomas L. Heavern, Jr., M.D., Newport
Charles Noss, M.D., Stanton
Reginald J. Phillips, Jr., M.D., Owensboro

Reference Committee No. 2—Scientific Assembly and Medical Education

Paul J. Parks, M.D., Bowling, Green, Chairman
Eugene H. Conner, M.D., Louisville
James A. Harris, M.D., Paducah
Robert J. Salisbury, M.D., Mt. Sterling
J. Sankey Williams, M.D., Nicholasville

Reference Committee No. 3—Legislative Activities

Carl Cooper, Jr., M.D., Bedford, Chairman
David A. Hull, M.D., Lexington
W. Faxon Payne, M.D., Hopkinsville
Charles E. Peck, M.D., Russell Springs
James C. Salato, M.D., Columbia

Reference Committee No. 4—Public Service and Allied Professions

Fred C. Rainey, M.D., Elizabethtown, Chairman
W. E. Becknell, M.D., Manchester
Kenneth P. Crawford, M.D., Louisville
Robert E. Robbins, M.D., Greenville
James B. Tolliver, M.D., Whitesburg

Reference Committee No. 5—Medical Service

Walter I. Hume, Jr., M.D., Louisville, Chairman
James L. Ferrell, M.D., Paris
Robert T. Johnson, M.D., Beaver Dam
William J. McNabb, M.D., Louisa
Thomas G. Parker, M.D., Murray

Reference Committee No. 6—Constitution and Bylaws; Special Committees

W. Vinson Pierce, M.D., Covington, Chairman
John M. Baird, M.D., Danville
Herman Mahaffey, M.D., Louisville
Eugene L. Marion, M.D., Glasgow
J. M. Stevenson, M.D., Brooksville

Reference Committee No. 7—Miscellaneous

Irving F. Kanner, M.D., Lexington, Chairman
Robert Chambliss, M.D., Burkesville
Harvey Page, M.D., Pikeville
James G. Sills, M.D., Hardinsburg
W. Fielding Rubel, M.D., Louisville

The Speaker stated the tellers for the meeting would be Edward C. Bowling, M.D., Stanford, Chairman; C. V. Dodson, M.D., Russellville; and John O. Jones, M.D., Flatwoods. Doctor Brockman also stated that the KMA Delegates and Alternate Delegates to the AMA had been assigned to reference committees and would be serving as resource people during the committee hearings.

The reports of the officers and committees were presented at this time and referred to the respective reference committees by the Speaker as follows:

Report of the President—Reference Committee No. 1

Report of the President, Women's Auxiliary to KMA—Reference Committee No. 1

Report of President-Elect—Reference Committee No. 1

Report of Speaker of House—Reference Committee No. 1

Report of Chairman, Board of Trustees—Reference Committee No. 1

The Speaker then recognized William Bizot, M.D., the chairman of the Awards Committee, for his nominations for the Distinguished Service Medal, and the Outstanding General Practitioner Award. W. Vinson Pierce, M.D., Covington, was nominated for the Distinguished Service Medal. A motion was made, seconded and carried that Doctor Pierce be the recipient of this award.

The name of John C. Baker, M.D., Berea, was placed in nomination for the Outstanding General Practitioner Award. The motion was seconded and carried.

The House recessed at this time for a coffee break provided by the Kentucky State Association of Medical Assistants.

After reconvening the House, Doctor Sweeney continued with the assignment of the reports to the various reference committees as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

Report of Executive Secretary—Reference Committee No. 1

Report of the Council on Scientific Assembly—Reference Committee No. 2

Report of the Council on Medical Education and Hospitals—Reference Committee No. 2 with the following exception: page 6, near the bottom of the page, starting with "The Kentucky Academy of General Practice, Congress of Delegates" and ending on page 7 at the conclusion of the first full paragraph found at the end of the resolution, referred to Reference Committee No. 5

Report of the Council on Legislative Activities—Reference Committee No. 3

Report of the Council on Medical Services—Reference Committee No. 5 with the following exceptions: page 2, third paragraph, referred to Reference Committee No. 6; page 14, starting with the first paragraph at the top of the page through the conclusion of the report, referred to Reference Committee No. 4

Report of the Council on Communications and Public Service—Reference Committee No. 4

Report of the Council on Allied Professions and Related Groups—Reference Committee No. 4 with the following exceptions: page 2, starting at the beginning of the second paragraph top of page 2 and ending with the paragraph at the top of page 3—also, "Board Action" bottom of page 43 and addendum of TB Committee after page 44 referred to Reference Committee No. 5; page 14, numbered paragraph 2 referred to Reference Committee No. 6

Report of the Advisory Committee to the Editor—Reference Committee No. 6

Report of the Judicial Council—Reference Committee No. 6

Report of the Committee on Third Party Medicine —Reference Committee No. 6

Report of the Committee to Study the Constitution and Bylaws—Reference Committee No. 6

Report of the Interim Meeting Program Committee—Reference Committee No. 6

Report of the Insurance Review Board—Reference Committee No. 6

Report of the Board of Directors, Kentucky Physicians Mutual, Inc.—Reference Committee No. 5

Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund—Reference Committee No. 5

Report of the McDowell House Committee—Reference Committee No. 7

Report of the Memorials Commission—Reference Committee No. 7

Report of the Technical Advisory Committee on Indigent Medical Care—Reference Committee No. 5

Report of the KMA Representative to Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 7

Report of the KMA Representative, U. of K. Chapter, Student AMA—Reference Committee No. 7

Report of the KMA Representative, U. of L. Chapter, Student AMA—Reference Committee No. 7

Report of the Advisory Committee to Selective Service—Reference Committee No. 5

Report of the Representative, Advisory Committee on Maternal and Child Health, State Department of Health—Reference Committee No. 7

New Business

The new business was then presented to the House and referred to the reference committees by the Speaker as follows:

(A) Resolution of KMA Board of Trustees on the subject of Surveying of Physicians' Fees—Reference Committee No. 5

(B) Resolution of Franklin County Medical Society pertaining to Fee for Service under "Medicaid"—Reference Committee No. 5

(C) Resolution of Jefferson County Medical Society relating to Improvement of the State Medical Assistance Program—Reference Committee No. 5

(D) Resolution of Jefferson County Medical Society on the subject of Study Committee for Coordinated Community Health Care—Reference Committee No. 4

(E) Resolution of Muhlenberg County Delegation pertaining to Utilization Committees in Accredited Hospitals at all Levels in Kentucky—Reference Committee No. 2

(F) Resolution of Muhlenberg County Medical Society pertaining to Selective Service—Reference Committee No. 7

(G) Resolution of Fayette County Medical Society on the subject of Direct Billing—Reference Committee No. 5

(H) Resolution of Fayette County Medical Society pertaining to Direct Billing—Reference Committee No. 3

(I) Resolution of Rowan County Medical Society concerning Question of KMA Policy—Reference Committee No. 1

(J) Resolution of Pulaski County Delegation concerning The Doctrine of Individual Responsibility—Reference Committee No. 5

(K) Resolution of Pulaski County Delegation on the subject of Section 1801—Public Law 89-97, Resolution 69—Reference Committee No. 5

(L) Resolution of Pulaski County Delegation relating to The Right to Bill Patients—Title XIX of Public Law 89-97—Reference Committee No. 5

(M) Resolution of Barren County Medical Society pertaining to Accreditation of Kentucky Hospitals —Reference Committee No. 2

The meeting places for the nominating Committee for general officers and the six trustee districts were announced by the Executive Secretary. He pointed out that the Nominating Committee would report immediately at the close of the first scientific session on Tuesday morning at the Convention Center, and these nominations would again be read at the second meeting of the House on Wednesday, when according to the Bylaws, additional nominations could be made from the floor without discussion or comment.

The first session of the House was adjourned at 12:00 Noon.

Second Session

The second session of the House of Delegates was called to order on September 21 by the Speaker, George F. Brockman, M.D. Everett H. Baker, M.D., Louisville, president, gave the invocation. The Chairman of the Credentials Committee, Donn L. Smith, M.D., Louisville, reported that a quorum was present.

The Speaker recognized the Chairman of the Board of Trustees, Hubert C. Jones, M.D., who presented the final report of the Board of Trustees as follows: (The Board of Trustees passed this resolution at its September 21 meeting)

"WHEREAS, the 1966 Annual Meeting of the Kentucky Medical Association has been well attended and generally accepted as being one of the outstanding meetings that the Association has held, and

"WHEREAS, the Council on Scientific Assembly, our guest speakers, sixteen cooperating specialty groups and all others worked together so successfully in developing the outstanding scientific program, and

"WHEREAS, the University of Louisville with the cooperation of the University of Kentucky has developed and presented a most profitable color TV program of four and one half hours in length, and

"WHEREAS, the Smith, Kline and French Laboratories, at considerable expense, used their color TV broadcasting facilities to greatly enhance the effectiveness of our meeting, and

"WHEREAS, the staff of the Kentucky Hotel, along with many other organizations and individuals, have cooperated to help make this meeting successful,

"NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Kentucky Medical Association go on record as expressing its deep appreciation to all individuals and organizations that had any part in developing and presenting the 1966 Annual Meeting." Doctor Jones moved the adoption of the resolution. The motion was seconded and carried.

Doctor Asman presented the announcements for the evening. He recognized the following representatives of state medical societies: Henry A. Crawford, M.D., Cleveland, Ohio, past president of the Ohio State Medical Association; Newton DuPuy, Quincy, Illinois, president-elect of the Illinois State Medical Society; Richard E. Flood, M.D., Weirton, West Virginia, president of the West Virginia State Medical Association; Kenneth O. Neumann, M.D., Lafayette, Indiana, president of the

Indiana State Medical Association; and Byron Stuart, Boonville, Missouri, president of the Missouri Medical Association.

Following the announcements, the reports of the reference committees were then presented.

REFERENCE COMMITTEE No. 1†

Thomson R. Bryant, Jr., M.D., Chairman

Reports of Officers and Board of Trustees

Reference Committee No. 1 considered the following reports:

1. Report of the President
2. Report of President, Woman's Auxiliary to KMA
3. Report of President-Elect
4. Report of Speaker of the House
5. Report of Chairman of Board of Trustees
6. Report of the Secretary
7. Report of the Editor
8. Report of the Treasurer
9. Report of the AMA Delegates
10. Report of Executive Secretary

Resolution I—Rowan County Medical Society

Report of the President

The year 1965-66 has been a busy and pleasant year for your President. Through your kindness and cooperation many enjoyable hours have been spent serving the KMA.

Shortly after the 1965 Annual Meeting, we visited Danville and accepted a plaque from the Department of the Interior in recognition of the McDowell House. In October 1965, we attended a special called meeting of the AMA House of Delegates in Chicago. Also in this month we attended the annual meetings of the Licensed Practical Nurses, Registered Nurses, Rural Electric Association, Mental Health Committee and the ARHI. Meetings were also attended with the KMA Executive Committee and the Scientific Assembly.

November dates consisted of meetings with nursin home administrators, KEMPAC, KMA Judicial Council, KMA Interim Meeting Planning Committee, and a meeting with Governor Breathitt regarding health centers. There were special meetings in December regarding PL 89-97, a meeting of the Board of Trustees and another conference with Governor Breathitt. In January there was a meeting of the committee dealing with governmental medical services, a meeting of the Council on Allied Medical Services, a district meeting at Owensboro, a town and gown meeting at Park Mammoth for three days and a district meeting at Paducah.

In February and March, meetings were attended as follows: Jefferson County Medical Assistants Association, Key Men of KMA, Allied Council meeting, Utilization and Review meeting, a district meeting at Shelbyville, KMA Structure and Re-organization Committee meeting, Metropolitan Insurance representatives, Budget Committee, University of Louisville Senior Day, University of Kentucky Senior Day and an address to employees of the Office of Economic Security in Louisville.

The important happening in April was the Interim Meeting at Cumberland Falls with interesting discussions, excellent attendance and an address by Doctor Appel, AMA President. Then there were district meetings in Ashland, Covington, Louisville, and Lexington that were attended. The annual Washington dinner for our Kentucky legislators and their wives was held at the Mayflower Hotel. This was an extremely pleasant occasion and it seems to be worth every bit of our effort and expense. The meetings of the National Education Association, of Licensed Practical Nurses and the Kentucky Hospital Association were attended.

In May we attended two sessions and the banquet of the annual meeting of the Kentucky Academy of General Practice. There was also a district meeting at Somerset, Rural Kentucky Medical Scholarship meeting, Committee on Disaster Medical care meeting, and the Kentucky Association of Medical Assistants.

June was a busy month. District meetings at Middlesboro, Madisonville, Elizabethtown, and Bowling Green were addressed. There were several committee meetings on the KMA level and then the Annual Meeting of the AMA in Chicago where our delegates did an outstanding job.

July found us very active with the Board of Trustees and all of the physicians and their organizations concerning fee schedules in the expanded medical care program for indigents. In every area the voting was unanimous that we recommend to the Governor's Advisory Council on Medical Assistance that "usual, customary, and reasonable" fees for all physicians be paid for services rendered. At our first meeting this was not accepted, but the door was not completely closed as further study and exploration was promised.

In August the Executive Committee and the Board of Trustees met preparatory to the Annual Meeting in September.

In addition to the activities listed there were visits to state medical meetings in adjoining states, conferences by telephone, conferences with insurance carriers and studies with many groups of Title 18 and Title 19 and the preparation for the impact of Heart, Stroke, and Cancer centers, and the effect this will have on medical practice, medical education and patient care.

Everett H. Baker, M.D., President
Kentucky Medical Association

Recommendations, Reference Committee No. 1

The portion of the Report of the President to the 1966 session of the House of Delegates, which was referred to Reference Committee No. 1, was reviewed. The Committee wishes to recognize the outstanding and efficient service of the President.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Report of President Woman's Auxiliary to KMA

Physicians' wives in Kentucky this past year have concentrated on our responsibility to our past, our present and our future.

We have remembered through our association with McDowell House our responsibility to our forefathers.

On September 29, 1965, my first official duty as President of the Woman's Auxiliary to the Kentucky

†*In order to make the Digest of Proceedings of the second meeting of the House of Delegates more understandable and because it will occupy less space in the Journal, the KMA Board of Trustees passed the following motion "That if no dissenting action on the committee's recommendations is made either by the council under which the committee serves or the KMA Board of Trustees, only the reference committee action on the report be printed in The Journal".*

Medical Association was to represent the auxiliary at the ceremony marking McDowell House as a registered historical landmark. In November, small sterling-silver charms, exact replicas of McDowell House and Apothecary, were made and placed on sale at the House. This charm is the only one in the State of Kentucky that is a replica of an historical house and was presented to the public in a short paragraph by Joe Creason in his daily column in the Louisville Courier Journal. This was excellent publicity for the House.

I have presented programs on this beautiful home and its fascinating story at nearly every auxiliary visit. I was amazed to find that many of our members knew very little, if anything, about this landmark.

As of July 20th, the Department of Public Information of the State of Kentucky has sent out a story by Mrs. James Rich, past president of the Auxiliary to the KMA, regarding the House and the Apothecary Shop. We need to get information of this type to the general public. I hope that the Auxiliary has started this ball rolling.

About this time last year the papers printed pictures showing residents of Kentucky unloading books, clothing and other such articles sent by other states into the highly publicized Appalachian area of our state. I asked our members in my inaugural address if we were going to sit back and let others assume our responsibility? Indeed not! At our post convention Board meeting plans were put into effect to work with the Frontier Nursing Service, Wendover, Kentucky. We have sent good, clean, used clothing by the truck loads to Wendover. Toys were sent to be used by little patients in the waiting rooms of the five clinic outposts. Aprons were made to be worn by the nurses at the clinics and during home deliveries. Small cloth bags used to carry supplies were also made. Several counties have sent layettes and one county sent one dozen new sheets to be used in the hospital and several counties have sent cash donations.

In March, Floyd-Johnson-Magoffin Auxiliary made a trip to Wendover to see first hand the work of this group. In May a group of members from central Kentucky chartered a bus and toured the Red Bird Clinic outpost, the hospital and the administrative quarters at Wendover. At this time four cartons of drugs were taken up and since then two more have been sent. We have shown our concern for our neighbor through this work and have also shown our responsibility to the present.

We recognized our responsibility to the future through our emphasis on legislation. KEMPAC membership was stressed this year and in Feburary a trip to Frankfort was organized. A group of 44 members met on a sunny morning, Feburary 9, 1966, and under the leadership of Mrs. A. S. Holmes, legislative chairman, and Mrs. Harry Cowherd of Frankfort, we toured the capitol. Mrs. Norman Nedde, Assistant Attorney General and a member of the University of Kentucky WA-SAMA, and Mrs. Nell McNamara, representative from Mt. Sterling, arrangements were made for us to have lunch in the private dining room. Following lunch, Dr. Mitchel Denham, Speaker Pro Tem of the House, spoke to us as did Dr. H. D. Gardner, of the KEMPAC Board. Representative McNamara arranged for us to meet the Governor—he was most surprised to find that we had no favors to ask of him—we were merely an interested group of citizens. We then went off to meet our respective senators and representatives and later observed both chambers in session. This proved to be quite an eye-opener for all of us and I'm sure we will all be more interested in what is done in Frankfort and Washington and the type of people we send to represent us.

The interest aroused by this trip and the effect of medicare has caused us to arrange a legislative workshop to be held the afternoon before the formal opening of the convention.

The Board voted to present a certificate of appreciation to Mrs. Nell McNamara for her service to the people of Kentucky through her work on the Public Health Committee during her two sessions in Frankfort.

Although membership has not increased this year I feel our members are extremely interested in auxiliary and the amount of community service they have done proves this. We are proud to welcome Christian County into the state organization this year and we have six counties with 100% member-at-large membership.

Although we have concentrated on the afore mentioned projects our women have been active in other phases of auxiliary work.

Mrs. Robert Long, AMA-ERF chairman, reports an increase this year of $1,421.02 or 70% increase over last year for a total contribution of $3,444.14. Although this is an excellent increase and we are proud of it we only stood 5th in the Southern Region this year. Let's try to be first next year!

International Health Activities again proved to be a very popular project with nearly all 30 auxiliaries participating in bandage rolling, johnny coats and drug collection all to the amount of 75 cartons or 1,185 pounds plus 400 pounds of drugs to Frontier Nursing Service and four cartons of tranquilizers to the Pike County Mental Health Clinic.

Individual families have participated in International Hospitality by inviting foreign students, interns and residents into their homes. One county has invited the wives of foreign physicians at the local state hospital to attend their meetings.

We have eight health career clubs and two future nurses clubs organized in our high schools throughout the state. There are nine loans, two scholarships and one student currently using the state loan fund. Although only two Career Days or Fairs were held this year these were very successful and it is hoped that more can be held in the coming year. Our loan booklet is in the process of revision and will again be sent to all high schools and colleges.

Water safety was again stressed this year by the safety chairman with only one county reporting a program on this timely subject although safety in the home, poison control, GEM programs and driver training were stressed.

We are most proud of our WA-SAMA groups. The University of Louisville Chapter has applied for membership in the National organization. The University of Kentucky, although only five years old, was named the chapter of the year at their National Convention this past spring. Mrs. Norman Nedde, a member of the U. of K. Chapter, was named President-Elect of the National organization. These girls will make up WA-KMA within the next few years. With such talent and enthusiasm to come into our ranks we should continue to grow and become an outstanding auxiliary. We are all most proud of these young women.

Community service projects truly reflected local needs and interest. Health education, immunization programs, help for the handicapped, physical fitness, diabetic detection, glaucoma screening, visual and audiology screening, bloodmobiles, plus volunteer service in hospitals, clinics and health departments have all benefited from the services provided by these talented and interested women. For the 11th year a health citation award will be given to the lay person or organization for an outstanding contribution in the field of health. This year for the first time an award will be given to a physician's wife who has made an outstanding contribution to her community. This will be an annual award.

Mental health has grown by leaps and bounds this year. One county raised over $1,000 for its mental health clinic, several made donations for a swimming pool at Outwood Hospital, Christmas

gifts were sent to both Outwood and the hospital at Frankfort by several groups. Plans were made for a new mental health clinic in another county and Jefferson County hosted the Mental Health Conference held in Louisville last October, one county continues to serve as volunteers in their clinic plus conducting a survey of their county to determine the needs in the area of slow learners and the mentally retarded. Six counties reported using the records, "Mirror to the Mind". We are all proud of Mrs. C. C. Lowry of Calloway County who is serving as president of Kentucky Federation of Women's Clubs. She plans to stress mental health in her program this year.

I have visited 17 of the auxiliaries this year, installing officers, presenting programs and generally speaking up for auxiliary.

I attended the historic ceremony at Danville, September 29, 1965, marking McDowell House a National Monument, the Fall Conference for Presidents and Presidents-Elect in Chicago in October 1965 as well as the workshop in Atlanta, Georgia that same month. The following month I attended an Interim Planning meeting in Harrodsburg, KEMPAC Board meeting in November, 1965, installed officers for the University of Kentucky WA-SAMA Chapter, February 1, 1966, and attended the 7th District meeting in Shelbyville and a day in Frankfort the same month. I attended the Interim Meeting, Cumberland Falls, April 13 and 14 and was sent as a delegate to the 8th annual visit to Washington on April 25, 1966. On May 3, 1966, I made a trip to Frontier Nursing Service, Wendover, Kentucky and May 25 attended the 12th District meeting in Somerset. A death in the family prevented me from attending the 13th District meeting in Ashland April 13th. On June 1st I served as a member of a panel for the WA-SAMA program at the University of Kentucky.

I attended the annual House of Delegates meeting of the WA-Indiana State Medical Association in Fort Wayne, April, 1966, and the annual meeting of the WA-to the Wisconsin Medical Association in May, 1966. State visitation prevented me from attending the Tennessee, Missouri and Ohio State meetings. I attended the convention of the Woman's Auxiliary to the AMA and presented the Kentucky president's report at that time.

I presided at four Board meetings and the 44th Annual Meeting of the Woman's Auxiliary to Kentucky Medical Association, September 20 and 21, 1966.

Articles have been written for four issues of the Blue Grass News, the President's page of KMA Journal (January issue) and a report on Kentucky Auxiliary activities for the National Archives and the KMA.

This year KMA accorded recognition to the auxiliary by inviting your president to speak to the new members of KMA at Cumberland Falls and again on September 19, 1966, on "The Role of the Wife in Organized Medicine". I was also asked to present our auxiliary report to the KMA House of Delegates on September 19, 1966. I received several requests from different KMA committees for assistance plus requests from two of the trustees. I feel the Auxiliary has proven to our parent organization that we stand ready to be of assistance at all times. We have been truly blessed to have a parent organization which recognizes us as truly "helping hands", who have shared our hopes, guided our efforts and contributed to our financial support.

I sincerely thank the entire membership for their help and cooperation and for giving me this privilege and opportunity to serve as your president this past year.

Mrs. Robert Salisbury, President
Women's Auxiliary to the
Kentucky Medical Association

Recommendations, Reference Committee No. 1

The Report of the President of the Woman's Auxiliary to KMA to the 1966 session of the House of Delegates was reviewed. The Committee wishes to commend the members of the Auxiliary for their splendid work, particularly in their services to the Frontier Nursing Service, their emphasis on Legislative matters, encouraging KEMPAC membership, their fostering of nurse clubs and scholarships, their assistance with the McDowell House, and the 70% increase in contributions to the AMA-ERF.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the President Elect

As your president-elect, it has been a busy and eventful year. After three previous years of service on the Board of Trustees and one as Chairman of the Board, I have been greatly impressed by the rapid increase in activities the Association engages in on behalf of its members. One has only to look at the extra number of meetings, the hours spent by various members of committees, of the increased number and length of the meetings of the Executive Committee and the Board of Trustees in addition to the activities of an already overworked staff to realize the tremendous responsibilities facing medicine today as governmental regulation encrouches more and more into the private practice of medicine.

During the year it has been my privilege to attend the House of Delegates of the American Medical Association, both during the Annual Session last June in Chicago, and during the Interim Session in Philadelphia last fall. One cannot help but have a sense of pride in the fine work done by this body as a watch-guard for the health of the public and the advancement of medical science. It was enlightening to see the efficiency combined with democratic principals embodied in these meetings where the private physicians may have equal privileges of voicing their opinions together with the officials of the organization about the conduct of medical affairs. It was also educational to see the amount of work involved by our delegates and staff who attended these meetings of the House, the Reference Committees, their own discussions of the policies considered and how they might effect the economy and the practice of medicine in our own state. These meetings were tiring, lengthy and hard work, but the attendance of our delegation was perfect; and they were conscientious and sincere in carrying out their duties in our behalf.

It was also my privilege this year to serve as the only practicing physician on the Health Advisory Committee of the Appalachian Regional Commission. This required six trips to Washington for meetings which generally lasted two days. This was a broadening and enlightening experience to observe how a law and directive originating in Congress is formulated into a working policy with the numerous and varying interpretations given to these laws.

It has also been encouraging to see an increase in the number of physicians in the state who are showing an interest in the affairs of our organization. There are still all too many who consider the payment of their dues as their only obligation to their Medical Association, and to medicine as they would desire to see it practiced. Unless there is an awakening of a larger segment of our membership to become actively interested in the affairs of medicine and their Medical Association, there will be continued inroads and more governmental control over the private practice of medicine. It could not have been expressed better than Donald K. Dudderer, M.D., KMA Vice-President, Eastern District, stated in his editorial on the President's Page of the Journal recently when he said that we must "partici-

pate or capitulate".

We have indeed been fortunate in having such an articulate spokesman as our President and a Secretary and Chairman of our Board of Trustees who have been so self-sacrificing in giving their time to the interest of the members of the Kentucky Medical Association.

Robert E. Pennington, M.D.
President-Elect of KMA

Recommendations, Reference Committee No. 1

The Report of the President-Elect to the 1966 session of the House of Delegates was reviewed and the Committee wishes him much success in his duties in the coming year.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Report of the Speaker of the House

The bulging papers in your House of Delegates envelopes make it obvious that our colleagues this year have spent many hours planning for the betterment of our people and our profession. We are proud of those willing to give their time and mileage in doing our work. Their reports deserve thoughtful consideration.

We propose that the House follow the customary procedure.

Briefly, the Morning Session will include the presentation of the reports of officers, Board of Trustees, councils and committees. Each report is numbered. As they are received, each will be referred by number to a Reference Committee.

After all reports have been received, resolutions introducing new business will be in order. These will be alphabetically identified and referred to a Reference Committee.

This afternoon at 2:00 p.m., the seven Reference Committees will meet in the mezzanine rooms in this hotel. Your Speakers urge you to attend, participate in discussions, speaking freely but to the point.

Some will be interested in discussions at more than one Reference Committee. On a blackboard, each Reference Committee will list the reports in the order in which they will be considered. As testimony is completed on each item, a line will be struck through it. This allows you to schedule the best use of your time.

Each Reference Committee will hear testimony until at least 3:00 p.m. Later, in Executive Session, they will prepare reports. Every delegate will have a copy of all reports at the second meeting of the House on Wednesday night.

Your immediate Past Speaker, Garnett J. Sweeney, M.D., instituted a practice which we will continue. We are asking that any resolution longer than 20-25 words be reduced to writing with a copy forwarded to the Speaker.

Please remember that no document or action this morning expresses the policy of this Association. We are accepting information for study. Your action on Wednesday night will be the final decision—the policy of the Association.

The Speaker attended the Conference of Presiding Officers conducted by the AMA Speaker and Vice-Speaker during the AMA Convention. A number of distinguished medical parliamentarians participated in the instruction.

The Speaker has begun a complete library of the currently-available source material on parliamentary procedures. The books are at the speaker's table, together with information on price and source for any who might wish to study this interesting field.

Your Speakers are grateful for the opportunity of undertaking to serve you. We, the other officers, and the staff are here to help you make your decisions wisely and well. Call on any of us for any additional help.

George F. Brockman, M.D.
Speaker
Richard F. Greathouse, M.D.
Vice-Speaker

Recommendations, Reference Committee No. 1

The Report of the Speaker of the House to the 1966 session of the House of Delegates was reviewed. The Committee wishes to commend the Speaker and the Vice-Speaker for their splendid manner in expediting the business of the House.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report of the Chairman, Board of Trustees

You will find the following facts interesting. When I began to serve on the Board six years ago, most meetings started Thursday with a luncheon—occasionally there was a day-long meeting. As the Board's responsibilities increased, the day-long Thursday meetings became routine. With further expansion of Associational activities, we started the practice of beginning our meeting with a dinner and evening session Wednesday before the full day on Thursday. Even the Executive Committee is starting to meet on Wednesday evening before a day-long session on Thursday.

Beginning with the reorganizational meeting September 23, 1965, the Trustees have held four regular meetings and one called meeting. Members have traveled approximately 32,225 miles and spent over 1,125 man hours, working for you without reimbursement in any form. The Board was scheduled to meet yesterday, September 18, making the sixth for the year. The Executive Committee has also been busy having held six meetings this year.

You will appreciate that it is not feasible in this report to cover all of the acts of the Board and Executive Committee in the hundreds of pages of minutes that have been written. We can only hit the high points. However, all of the minutes are available for inspection at the KMA Headquarters Office.

With this meeting, I complete my tour of duty on the Board of Trustees. I continue to be amazed at the high percentage of attendance we have, the dedication of the individual members to the task of serving both their patients and their colleagues. The past two years, I think have been exceptionally difficult. Some problems seem to defy solutions, but the members of the Board show no disposition to give up.

I wish now to express my deep personal appreciation for the opportunity of serving on this Board and as its Chairman this year.

First Meeting, September 23, 1965

As Temporary Chairman, Henry B. Asman, M.D., secretary, called the meeting to order, he introduced the new officers of the Association as follows: Robert E. Pennington, London, as president-elect; George F. Brockman, Greenville, as speaker of the House; and Charles Rutledge, as the new KMA delegate to the AMA starting January 1.

Other new officers included the three Vice-Presidents: George Pedigo, Central District; Donald K. Dudderar, Eastern District; and C. C. Lowry, Western District; Richard F. Greathouse, Louisville, new vice speaker of the House of Delegates. Four new Trustees elected for a three-year term were Joseph Miller, Benton, First District; Henry Spalding, Bardstown, Fourth District; Robert F. Long, Somerset, Twelfth District; and James Archer, Paintsville, Fourteenth

District. David B. Stevens, Lexington, was introduced as the new KMA alternate delegate to the AMA.

Reelected to posts originally held were John Quertermous, delegate to the AMA; William W. Hall, KMA alternate delegate to the AMA and Gabe A. Payne, Jr., trustee for the Third District.

Hubert C. Jones was elected by acclamation to serve as chairman of the Board for the new year. Rex E. Hayes was elected as vice-chairman.

The Executive Committee was formed when Walter L. Cawood and W. Donald Janney were elected to serve with the President, President-Elect, Chairman, Vice-Chairman and Secretary as provided by the Bylaws.

After full consideration, the Board elected the personnel for councils and committees for the 1965-66 year. These recommendations were made by the Executive Committee in a manner prescribed by the Bylaws. Consideration was given to a problem relating to group practice. The resignation of Wyatt Norvell, as senior delegate from KMA to the AMA was presented and accepted with regret.

Brief reports were heard from the Sub-Committee on Cults and the ARHI ad Hoc Committee. Plans were made for obtaining nominations in the Fifteenth Trustee District to replace Robert E. Pennington, who had just become president-elect, as trustee. The Board made its plans to hold this election at the December meeting, the appointee to serve until the next meeting of the House of Delegates as provided by the Bylaws.

Second Meeting, December 8 and 9, 1965

Following the opening of the meeting and the customary announcements, the Board turned its attention to a matter relating to one of the larger groups in the state that had been pending for a long time. Full consideration was given to information developed by an investigation and after full discussion, the Board voted to drop the matter.

Ellsworth C. Seeley, M.D., London, was elected to serve the last year of a three-year term of Robert E. Pennington, M.D., also of London, who had been elevated to the office of president-elect.

The Board then set the date for the 1971 Annual Meeting and disposed of miscellaneous matters.

Eugene H. Conner, M.D. was elected to the chairmanship of the KMA Memorials Commission replacing the late Carlisle Morse, M.D.

After hearing the request that the KMA publish a directory of KMA members giving phone numbers, office hours, and specialties, the Board voted to appoint a committee that would give this matter careful study and report back to the Board.

The KMA Board nominated three members for consideration of the Governor, as provided by the Statutes, to fill an appointment expiring December 31 on the State Board of Health. It then heard a report from Tom Wallace, M.D., director of the Louisville-Jefferson County Health Department, on an AMA-sponsored meeting covering venereal diseases.

Multiple recommendations from the KMA Council on Legislative Activities were considered and disposed of.

The KMA Delegates on October 2 and 3 and the regular Interim Meeting, November 28-December 1.

It will be remembered that at the close of Reference Committee Report #3 during the last session of the House of Delegates, Wednesday, September 22, the House voted to refer the entire Reference Committee Report No. 3 to the Board of Trustees after being unable to agree on the interpretation of the issue of "participation". It was decided at that time that the Board of Trustees would be able to act on this matter after the special October 2 and 3 meeting of the AMA House of Delegates.

The Board of Trustees considered the actions of Reference Committee #3 and adopted the report as a whole (as amended by the House) and directed the General Counsel of the Association to present in the January 1966 Communicator (KMA Newsletter) the circumstances under which any KMA member might legally refuse to participate under PL 89-97. This was done in the January 1966 issue and additional copies of this statement are available on request.

The Special Ad Hoc Committee of the Board to Study PL 89-97 recommended that the Kentucky Blue Shield be designated as the carrier under PL 89-97, Title XVIII, Part B. The Board unanimously approved this request.

There was discussion relative to the joint meeting on medical education between the U. of L. and U of K. faculties and representatives of the KMA January 22 and 23 at Park Mammoth Resort. It was agreed that approximately 15 from each one of the medical schools and 30 from KMA would constitute the representation at the conference.

At this point representatives of the State Board of Health who had previously been invited to the meeting appeared and matters of mutual interest were discussed.

The full minutes of this meeting are on file at the KMA Headquarters Office, and any member wishing to read them may do so.

Third Meeting, April 12 and 13, 1966

After covering the necessary announcements for the two-day meeting and the routine reports, the Board considered a recommendation from the Committee to Study Medical Practices in the ARHI institutions.

The Board of Trustees then considered the nominations for members of the Board of Directors for the Kentucky Educational Medical Political Action Committee and made its selections.

Paul I. Robinson, M.D., Rye, New York, vice-president and medical director for the Metropolitan Life Insurance Company of New York was introduced by Chairman Hubert C. Jones, M.D., Berea. Doctor Robinson explained how his company happened to be named the carrier for Kentucky under PL 89-97, Title XVIII, Part B. It was indicated that many of the regulations had not been formed at that time, and he was not able to give the full story on how the medicare plan would be implemented in Kentucky. He answered a number of questions.

The Budget Committee made its report for the proposed 1966-67 budget. It was explained that the Budget Committee had spent a day in preparation of the budget and that the Executive Committee had devoted a considerable amount of time to it. It was pointed out that there were no radical changes proposed for the new budget. After consideration, it was adopted.

Recommendations of the KMA Hospital Committee relating to area-wide planning were approved. Consideration of the location of the 1967 Interim Meeting was left up to the Executive Committee. Recommendations of the KMA Technical Advisory Committee on Indigent Care (which related to the implementation of PL 89-97, Title XIX in Kentucky) were debated at great length and eventually approved. At the same time, the Board voted to resist the so-called "preventicare" proposal.

The Ad Hoc Committee to Study the Council and Committee Re-Organization report was made, carefully considered and approved. In addition, a motion to continue the committee and enlarge its personnel and broaden its responsibility passed. The Board disposed of a matter relating to the orientation course and heard a report on the developments of PL 89-239, the heart, cancer and stroke program.

Kenneth P. Crawford, M.D., Louisville, who had attended the AMA Conference on Voluntary Health Associations at the request of KMA, gave a report of the meeting to the Board.

A series of recommendations from the Council on

Legislative Activities was presented. It was voted to advise the membership that the individual was not required to sign the statement of compliance. A report on the 1966 Kentucky General Assembly was heard together with comments on strengthening the KMA Legislative Key Man system. The Board voted to resist the efforts of the Department of HEW in the policy of using "generic equivalent drugs".

The report of the Ad Hoc Committee to study the publishing of a KMA directory was made, considered at great length, and it was decided to have the committee to continue studying the matter and come back with a firm proposal. The special Ad Hoc Committee of KMA to Study PL 89-97, Title XVIII, Parts A and B, reported to the Board. The recommendation of the committee that KMA cooperate with the Kentucky Hospital Association and the Kentucky Blue Cross in seeking to use computers to aid utilization review committee work was accepted.

The Board also voted to ask the KMA Insurance Review Board to be the statewide arbitration group to cooperate with the Metropolitan Life Insurance Company, the carrier under Part B. After full discussion of the financial problems facing the AMA, the Board voted to authorize the KMA Delegates to the AMA to support the increase in dues.

The Board approved the request of the University of Kentucky Department of Community Medicine relating to use of medical students in a summer research program, authorized the study of coverage for possible liability which might accrue to certain agencies, voted to accept the letter from Carroll L. Witten, M.D., Louisville, withdrawing from the race for vice-speaker of the AMA House of Delegates, and approved the request of health commissioner Russell E. Teague, M.D., to name representatives on the laboratory advisory committee and took action on a number of special dues requests.

It was decided that the date of the next meeting would be Wednesday and Thursday, August 3 and 4.

Fourth Meeting, July 6, 1966

On Wednesday, July 6, the Board of Trustees of the Kentucky Medical Association held a special called meeting for the purpose of reviewing the recommendations for expansion and revision of benefits of the Kentucky Medical Assistance Program as approved by the Governor's Advisory Council for Medical Assistance at its June 13, 1966 meeting.

Discussants of the program included representatives of the KMA Technical Advisory Committee to the Governor's Advisory Council, representatives of the Kentucky Academy of General Practice, and the Commissioner of Health, Russell E. Teague, M.D. and his assistant, William McBeath, M.D.

Following questioning of these men by members of the Board and full discussion, three recommendations were made.

It was pointed out in considerable detail that experience has shown "fixed" fee schedules have a strong tendency to increase the cost of medical care. This has been the experience of the program to provide medical care for the dependents of active members of the armed forces, by the Metropolitan Life Insurance Company and by the United Automobile Workers and other groups. For these reasons, members of the Board of Trustees were in agreement that the usual, customary and reasonable fee approach would save the Department of Health and other agencies money in the administration of these programs.

The Board then formally voted to endorse the concept of compensation of all physicians on the basis of their usual, customary and reasonable fee and strongly recommended that this be applied in the implementation of all medical care programs under PL 89-97.

There was a full discussion on what governmental agency in Kentucky would serve the best interests of the people in administering medical care programs. The Board of Trustees then voted to recommend to the Governor's Advisory Council on Medical Care that the proposal to expand the public assistance program and similar programs be administered financially and otherwise through the Department of Health.

Members of the Board recognized there would be a minimal number of disagreements between the Department and the individual physician in the administering of the expanded medical assistance program as proposed. The Board then voted to offer the services of the KMA Insurance Review Board to the Department of Health in reviewing these cases.

Fifth Meeting, August 3 and 4

The fifth meeting of the Board was held in four sessions beginning early Wednesday afternoon and ending late Thursday.

The Legal Counsel reported that to date he had been unable to find a liability policy covering Association officers in carrying out their duties.

The resignation of Sam A. Overstreet, M.D., Louisville, who had served as editor of The Journal for eight years was accepted with deep appreciation and his Associate, Walter S. Coe, M.D., Louisville, was elected for a two-year term. At Doctor Coe's suggestion, the Board elected Doctor Overstreet as associate editor for a two-year term and created the new post of Assistant Editor and elected Walter I. Hume, Jr., M.D., Louisville, to fill that post.

The Morehead matter was reviewed and resolutions presented by the Fayette County Medical Society in the area of direct billing and third party connections were carefully considered and passed.

The revising of the fee schedule for the ODMC contract, which had not been changed for six years, was discussed. It was indicated that the renewal date of July 1 had been changed to December 1 and the Executive Committee was authorized to give active consideration to this problem.

The Board expressed its appreciation to the Kentucky Surgical Society for a $1,000 contribution to the McDowell House and picked Ken-Bar Inn, adjacent to and just west of Kentucky Lake State Park for the site of the 1967 Interim Meeting and fixed the date as April 19 and 20.

The Board heard a report of a special joint meeting between the Executive Committee and the physician members of the Board of Health, which had been held in executive session. The Executive Committee, as a result of this meeting, had recommended that the Board give consideration to carrying out a study which would provide information on fees that would enable the medical care division to predict costs in the implementation of Title XIX. The Board referred the matter back to the Executive Committee and asked it to explore the possibility of such a survey in depth.

Approximately two of the four sessions held during this two-day meeting were devoted to hearing reports of councils and standing committees as provided in the Bylaws. Since action on each council and committee report will be printed at the conclusion of all of these reports which are considered by the House of Delegates, they will not be reported here.

In considering separate recommendations to the Board from committees and councils, the Board approved the request of the School Health Committee for the use of a room in the Convention Center during the Annual Meeting. A recommendation from the Public Health Committee that KMA encourage county medical societies to participate in the introduction of VD instructions in the schools in the counties, and the request that information on laws relating to infectious diseases be included in KMA Orientation Programs was approved.

From the KMA Blood Banks Committee came a recommendation to the Board asking for KMA

support of a bill in Congress, S1353, concerning blood banks and antitrust laws and the approval of a statement relating to payment of money indemnities under health insurance contracts.

A recommendation from the KMA Diabetes Committee concerning the use of blood sugar testing kits to be prepared by the State Department of Health and used by the county medical society diabetes chairmen was disapproved. Reasons given included that this would involve extra expense for the already tight budget of the State Department of Health and that present procedures using Ames products were satisfactory.

The dates of September 7 and 8 were set for the next meeting of the Executive Committee, which would among other things, make nominations for personnel of committees and councils for the coming year.

The Board then set its own schedule for meetings to be held during the Annual Session on September 18, 21 and 22.

Hubert C. Jones, M.D.
Chairman of Board of Trustees

Recommendations, Reference Committee No. 1

The Report of the Chairman of the Board of Trustees to the 1966 session of the House of Delegates was reviewed. As indicated in the report, this dealt with each significant item in the various meetings of the Board of Trustees reflecting the tremendous scope of the material covered. It would be suggested that these reports be a little more detailed plus information regarding the action of the Board. The Committee wishes to commend the Chairman on his six years of excellent service on this Board.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was seconded and carried.)

Report of the Secretary

This report could well be a repetition of the two previous reports submitted by your Secretary since you elected him to this office three years ago. It would seem obvious, from the reports of the President and the Chairman of the Board, which you have just heard, that this has been a busy and trying year for KMA.

If any evidence is needed to indicate just how conscientiously the officers, Board, Council and committee members have endeavored to meet their responsibilities in carrying out the dictates of this House and conducting the day-to-day business of the Association as the chosen representatives of the entire membership, I would again resort to a few statistics.

In the ten and one-half months since the close of the last Annual Meeting to August 15, of this year, the Board of Trustees and/or Executive Committee of the Board have met on nine occasions. Four of these were two-day meetings. They were in session more than 60 hours, representing almost 1,300 physician-hours. In order to attend these meetings, 192 men travelled more than 40,000 miles.

KMA Councils and Committees held 75 meetings involving 528 physicians, were in session a total of 254 hours, and accounted for 1,855 physician-hours of effort in the interest of the Association. These men travelled almost 71,000 miles to participate in these meetings.

In each instance, these figures represent an increase of approximately 25% over the corresponding statistics reported to you one year ago. Even then they do not include the countless additional hours, or mileage, accumulated by the President, the Chairman, the Secretary and others in the performance of their duties and as representatives of the Association.

The equally impressive figures covering the activities of the Administrative Staff will be reported by the Executive Secretary.

It would seem that we still have not licked the problem of communication between the Headquarters Office and the individual members of the Association. The complete proceedings of this House are published in the December issue of the Journal, the COMMUNICATOR is sent to every member approximately once a month, and, during the past year, the Secretary has addressed special letters to the Secretary of each County Society from time to time in order to bring pertinent information promptly to the grass roots. Trustee district meetings have been held in almost every one of the fifteen districts during the past year in order to bring the leadership of the Association into direct contact with the members. And yet—it repeatedly becomes evident that many of our members have no knowledge of the major policies of the Association, that they have no idea of the mechanism by which these policies are established, nor do they have any conception of how the Association actually functions.

Just as our Delegates to the AMA report in considerable detail to the Board and to this House, so likewise do each of you have the obligation to report back to your county society on the actions of this House. Everyone in this Association has a right to disagree with its leadership. Criticism based on knowledge and understanding is constructive and helpful to all; based on ignorance it does injustice to those who are criticized and brings discredit to the critical member.

I would urge the Delegates to encourage the younger men in your communities to become more active in organized medicine—both on the county and on the State level. If any of you would like to suggest names for committee appointments, I am sure that Bob Pennington would be happy to hear from you before the Board meets on Thursday afternoon to finalize the Council and Committee structure for the coming Associational year.

Henry B. Asman, M.D.
KMA Secretary

Recommendations, Reference Committee No. 1

The Report of the Secretary to the 1966 session of the House of Delegates was reviewed. The Committee wishes to commend the Secretary on a job well done and especially commend him on his attempts to increase communications between the Headquarters Office and the members of the Association through the Journal and the Communicator and his other contacts through the county societies.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Report of the Editor

Your Editors have been striving to narrow the margin between the total cost of publishing and mailing our Journal of KMA and the revenue we receive from advertising. You are aware, of course, that there are three vital factors that have operated to the disadvantage of all state medical journals. They are:

1. Terrific competition with the national publications sponsored by medical organizations and the "controlled circulation" publications (throwaways).
2. Small journal four color advertising costs do not at all compare favorably with large volume national publications. (Advertisers are demanding more color).
3. Profit squeeze on the smaller pharmaceutical houses who formerly used our advertising columns.

In recent years, we have experienced two cost increases from our printer that have been occasioned primarily by increased costs of labor and paper to the printer. In addition, we have informed the State Medical Journal Advertising Bureau that we plan to increase our rates to advertisers averaging about ten per cent.

During the fiscal year which closed July 1, our income showed an increase over 1965 of twenty-four per cent. This does not include any revenue that is based on the new rate increase mentioned above.

For the same fiscal year, our expenses have increased 8.33 per cent. This only includes several months of the increase in printing costs.

Our State Medical Journal Advertising Bureau is working diligently to increase the revenue to all of the journals and is constantly seeking ways to cut costs.

Your editors would hope that the membership will not miss an opportunity to express appreciation to the representative of companies who purchase advertising space in our Journal and who thus allow us to maintain an increasingly attractive and helpful publication.

We trust that the KMA Journal has pleased you during the past year, and you may be assured that your Editorial Staff will constantly strive for improvement.

Walter S. Coe, M.D., Editor
Sam A. Overstreet, M.D., Associate Editor
Walter I. Hume, Jr., M.D., Asst. Editor
Joseph P. Sanford, Managing Editor

Recommendations, Reference Committee No. 1

The Report of the Editor to the 1966 session of the House of Delegates was reviewed. The Committee wishes to compliment the Editors on their successful efforts to put the Journal on a more sound economic footing.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was seconded and carried.)

Report of the Treasurer*†

Recommendations, Reference Committee No. 1

The Report of the Treasurer to the 1966 session of the House of Delegates with its attached financial statement prepared by certified public accountants was reviewed. The Committee, after studying the report carefully, feels that the finances of the Association are being handled in an efficient manner considering the heavy demands of the varied Association programs.

Recommendations, Reference Committee No. 1

Mr. Speaker, I move the adoption of this section of the report.

(The motion was seconded and carried.)

Report of the AMA Delegates

The Kentucky Delegates to the AMA in this past year have attended the Interim Meeting at Philadelphia and the Annual Meeting Session in June in Chicago. The Delegates attended all sessions of the House, attended their assigned Reference Committee meetings and spoke to support or oppose problems pertaining to practice of medicine, especially those pertaining to the State of Kentucky. Your Delegates held caucus meetings on Sunday night, Tuesday afternoon and evening and Wednesday morning of each of the sessions of the House during sessions of the House. At that time, our problems were discussed according to our directions from the Board of Trustees and consultation was asked for and received of all interested parties in an official capacity from the State, including your President, Chairman of the Board, and other interested physicians associated with Kentucky problems.

Most difficult problems pertaining to the practice of medicine which have become law at this time, namely the institution, promulgation and operation of Public Law 89-97 and its effect upon the practice of medicine throughout the country has been the most discussed subject at all of these meetings. Ramifications of the law pertaining to eligibility, hospitalization, billing and ultimate formation of committees necessary to handle all these problems have been thoroughly discussed. Conclusions were sought for which will be for the best interest of medicine and the patient at all times. Your delegates have attempted to bring back the frank, honest and impartial view to be presented to the Board of Trustees following these meetings, and detail information concerning these problems can be obtained from the Kentucky Medical Association.

The AMA this past year has had financial embarrassment because of extended lobbying which has been going on associated with the Medicare Laws. During the past year, it was apparent to AMA financial experts in order to maintain an active part in an advisory capacity pertaining to this new Medicare Law, additional finances would be indicated in order to keep up our educational programs which are now in effect. Despite some opposition at the recent meeting in Chicago, annual dues increase on the AMA level was authorized by the House of Delegates in order to uphold the highest traditions of the practice of medicine by public information and to carry on extended educational endeavors on a National level to prevent a further encroachment by Government on private practice, as has been predicted by extension of the Social Security Benefit laws. Further information pertaining to this can also be obtained from the Headquarters Office and detail information through the Journal of the American Medical Association and from the AMA Headquarters.

Multiple problems of the new law (Medicare) were brought forth in the annual session of the House, including methods of billing and accepting of assignments for service rendered, utilization committees and in-hospital based specialists. The question of displaced hospital specialists and other medical problems pertaining to implementation of the present law were subjected to much debate at the recent meeting in an attempt to clarify already existing problems of these specialists. The House decided to make a stand to call a halt to further hospital domination and this has already been brought to light in a Government antitrust suit.

There will in all likelihood be further tests of Medicine's attempt to call a halt to further government and hospital encroachment on the practice of medicine.

Additional specific information concerning the activities of your Delegates on the AMA level and their reports back to the Board of Trustees of the KMA can be obtained through State Headquarters.

J. Thomas Giannini, M.D.
Senior Delegate to the AMA

Recommendations, Reference Committee No. 1

The Report of the AMA Delegates to the 1966 session of the House of Delegates was reviewed. This reflects a great deal of activity for the year. The Committee wishes to commend the Delegates for a job well done.

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*(*Note*: *Any member wishing to see a copy of the Treasurer's Report may do so by writing the KMA Headquarters Office, 3532 Janet Avenue, Louisville, Kentucky 40205.)*

†*Please see October Journal of KMA Organization Section page 891 for graph showing distribution of KMA funds.*

Mr. Speaker, I move the adoption of this section of the report.
(Motion was seconded and carried.)

Report of the Executive Secretary

The volume of work performed by the Headquarters staff and the extent of activities in which it engages, are very much like the proverbial iceberg —only a very small percentage of our efforts are known to or seen by the membership.

We all enjoy our duties even as they increase with the advent of Medicare and other expanded programs. We believe we are rendering a very valuable service to you and to people you serve. We truly wish time and space here provided the opportunity to explain in greater detail the multitude of activities in which we participate.

This report will seek to highlight our work for the 1965-66 associational year by dividing it into five broad major categories.

1. Servicing of Committees, Councils, Board of Trustees, House of Delegates and Officers. Your House of Delegates envelope will contain nearly 300 pages. one report is 45 pages long. A very considerable amount of staff time is involved in working with this group as well as in the preparation of the approximately 60 reports contained in the envelope.

As your Secretary has reported, staff attended 174 KMA meetings (not including the 1965 Annual Meeting) in the last eleven months, for a total of 637 hours. Add to this the setting up of the meetings, researching agendas which must be approved by the appropriate chairmen, recording the minutes and implementing the actions taken by these groups.

2. Continuing Major Responsibilities. These include the Annual Meeting, Journal of KMA, Communicator, the Interim Meeting, the Orientation Course, and the Rural Kentucky Medical Scholarship Fund.

Preparations for the KMA Annual Meeting, while interesting, are very complex and time consuming. Already plans are being projected for the 1967 meeting, even as we make final arrangements for the 1967 meeting. Major efforts include the general sessions scientific programs, the setting up of the sixteen specialty group programs, the committing of 75 technical exhibitors, arranging for the scientific exhibits and some 40 committee and related meetings. Numerous contacts are made with the Convention Center management, the hotel management, decorators, sound projection and visual aids. There are numerous conferences, innumerable telephone calls and much correspondence on a year-round basis.

It is the responsibility of the Headquarters Office to make sure all material for The Journal of KMA is assembled and all deadlines are met and that The Journal gets out on time. Material for several of the twelve departments in each issue of The Journal is prepared in the Headquarters Office. Certainly, we are grateful for the opportunity of meeting every other Monday morning at 7:30 with our Editor and his Associate.

The KMA Communicator is prepared, processed and distributed under the supervision of our Secretary.

The Interim Meeting, which has experienced substantial growth in the last several years, is our second most important. Once policies are set, it is the responsibility of staff to commit the speakers, make arrangements and promote the meeting. A new record for attendance of 260 was set at the 1966 meeting at Cumberland Falls State Park.

The Indoctrination Course for new members of KMA is held twice a year. This major responsibility requires careful program preparation, record keeping and promotion for each session.

The Rural Kentucky Medical Scholarship Fund, as it broadens its services, offers more programs and increases in the number of recipients, has caused a corresponding increase in the amount of responsibility in its operation. We now have in the overall program 424 loans outstanding to 160 borrowers, for a total of approximately $450,000. All loans must be properly secured and covered by life insurance. Recipients are closely followed and kept aware of their obligations.

3. Special Projects. The 1966 meeting of the Kentucky Legislature was a very active session and sometimes tense. Our lobbyist was on hand at all times, and a second staff man was registered and served frequently as needed in the latter part of the meeting. Frequent special mailings are needed, which sometime require the emergency attention of practically all staff members. Phone calls run into the hundreds, and of course, there are many meetings and individual conferences. We were indeed pleased with the way staff performed during this year's legislature.

One new project has been the preparation of our mailing procedure to meet the Post Office Department's requirements for zip coding on mass mailings. The time-consuming task of obtaining the zip code number of all members, non-members, and other mailing lists routinely used by the Association, and stamping these numbers on the individual plates in approximately 3,000 instances, are well underway. Local postal officials have been very cooperative in helping us to work out these tedious regulations.

Another project of special interest during the past year has been staff involvement in the work of the Ad-Hoc Committee to Study and Improve the Organization of KMA. Considerable research is involved in this, checking with other states and reviewing our own procedures in order to become more efficient.

Two very interesting special projects each year include working with the Senior Day Committee and promoting the Senior Day Program in each of our two medical schools. The committing of the speakers, making arrangements with the schools and informing the students are among the staff duties.

Under the general head of health education, staff spends many hours in promoting the Diabetes Detection and Education Drive each year as well as the Immunization Week promotion. In addition, a number of health education exhibits are KMA sponsored at such meetings as KEA, State Fair and special occasions. Also, news releases are prepared and distributed from time to time.

4. Administrative. While activities in this area are primarily routine, they are nevertheless very important as the volume of the work that we handle continues to grow. Recruiting people in the present highly competitive market was necessary to fill four important jobs during the past year which resulted from a retirement, another whose husband moved away, and two others who found other jobs. As our operation has grown, more time is needed in preparing for the annual audit. Other responsibilities include departmental and individual staff supervision, purchasing, and maintenance of the building, grounds and equipment.

5. Miscellaneous Activities. Obviously it will not be possible to give a complete report on this. The implementation of the Medicare program and the confusion that has developed from the implementation of welfare and Title XIX programs has swamped the Headquarters Office with phone calls. There are many personal requests for answers to questions that involve research and checking with other states. These services we are pleased to render, and we hope that the membership understands that frequent interruptions tend to dilute staff efficiency.

As the problems of medicine become more complex, the volume of AMA mail to be read and the requests from the AMA for cooperation in carrying

out its work has increased by a corresponding amount.

With the Selective Service absorbing more and more men which includes practically all interns and residents and some in private practice, the number of calls on our placement service is growing proportionately.

Staff has represented the Association at 70 meetings with related interest. This gives staff an opportunity to interpret KMA policy and at the same time, bring back to the appropriate officers and committees what is taking place in other groups. The members of our executive staff maintain a close working relationship with the executive staffs of allied groups.

All of the members of the staff join me in expressing full appreciation to the President, the Chairman of the Board, the Speaker of the House, the Editors, and Council and Committee chairmen for their kind, considerate and efficient supervision and direction that have been given us during the year. Your tolerance of our shortcomings is most appreciated.

We would suggest that few of our members truly understand and appreciate the amount of time devoted by your Secretary and your Treasurer in serving the Association. The amount of time your Secretary spends in working with staff during the year will exceed 60 hours. Your Treasurer, who signs hundreds of checks each year, is equally generous with his time and valued supervision. Members of our staff profit greatly by the advice of these officers.

In conclusion, the Executive Secretary finds it difficult to express his full appreciation to and admiration for the other members of the staff in what has been accomplished during the year. Time and again, the members of the staff have demonstrated their willingness to go "above and beyond the call of duty" and for this, our appreciation knows no bounds.

J. P. Sanford
Executive Secretary

Recommendations, Reference Committee No. 1

The Report of the Executive Secretary to the 1966 session of the House of Delegates was reviewed. The Committee is impressed with the tremendous amount of work done by the Executive Secretary and his staff and wishes to express its appreciation.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was seconded and carried.)

Resolution I

Rowan County Medical Society

WHEREAS, the KMA Judicial Council on May 23, 1966, and the Board of Trustees of the Kentucky Medical Association on August 22, 1966, brought charges against Doctors Black, Bigler and Proudfoot for unethical practices, and

WHEREAS, at no time has any state officer of the KMA questioned, communicated with, or advised the Rowan County Medical Society regarding these charges, and

WHEREAS, all charges regarding these three members of the Rowan County Medical Society have been fully investigated by the named county medical society, which said society has found nothing unethical or incompatible with good patient care in the medical organization or medical practice of the community, and

WHEREAS, the established procedure for investigating grievances by District Grievance Committee, as per Chapter VII, Section 8, Paragraphs 1 through 3 of the Constitution and Bylaws of the Kentucky Medical Association was disregarded, now therefore be it

RESOLVED, that if there are objectionable medical practices in Rowan County, the verified and specific charges should be brought to the attention of the Rowan County Medical Society, and be it further

RESOLVED, that the State Medical Society from now henceforth consult with the County Medical Society regarding its own community health affairs, and be it further

RESOLVED, that in dealing with such complaints the accepted procedure provided in the Constitution and Bylaws of the Kentucky Medical Association be followed.

Recommendations, Reference Committee No. 1

Resolution I from Rowan County Medical Society was reviewed. Various opinions were heard including legal counsel. The Committee recommends that this Resolution not be adopted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 1 as a whole. (Motion seconded; carried.)

I wish to express my appreciation to the members of the Committee for their patience and perseverance.

REFERENCE COMMITTEE NO. 1
C. Melvin Bernhard, M.D., Louisville
Owen L. Davis, M.D., Scottsville
Thomas L. Heavern, Jr., M.D., Newport
Reginald J. Phillips, Jr., M.D., Owensboro
Thomson R. Bryant, Jr., M.D., Lexington,
Chairman

REFERENCE COMMITTEE No. 2†

Paul J. Parks, M.D., Chairman

Reports on Scientific Assembly and Medical Education

See note (†) bottom of column one, page 1122.

Reference Committee No. 2 considered the following reports:

11. Council on Scientific Assembly
12. Council on Medical Education and Hospitals

Resolution E—Utilization Committees in Accredited Hospitals at all Levels in Kentucky

Resolution M—Accreditation of Kentucky Hospitals

Report of the Council on Scientific Assembly

Preface

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the Bylaws, which reads in part:

". . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Scientific Assembly is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*

3. Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.

* * * * * *

The Council on Scientific Assembly met early in this Associational Year and one of the first matters to consider was a review of the format and operation of the scientific sessions and other related activities of the 1965 Annual Meeting. 1965 marked the second year that the KMA Annual Session had been held in the Louisville Convention Center, and your council was well satisfied with the facilities and layout of the meeting.

Noise drifting from the technical exhibit hall to the scientific assembly area was a reported problem at the 1964 meeting and efforts have been made continuously to eliminate this undesirable factor. We have now moved the technical exhibit hall about ten feet farther away from the scientific sessions, put up a double row of heavy curtains creating a dead space between the two, and enclosed the registration booth on three sides to minimize possible noise from typewriters and registrants. Your council now feels that any noise problem that existed has been virtually eliminated.

A new attendance record of 2,186 registered at last year's meeting. Of this amount, 1,172 were KMA members, over 50% of the Association membership. Your council enthusiastically accepted this report and is using this means to bring it to your attention.

We are pleased to report that again a record sixteen specialty groups are meeting in connection with this year's Annual Session, and we are most appreciative of the cooperation that the specialty groups have evidenced. Approval by the specialty groups of the facilities offered by the Convention Center for their afternoon specialty group meetings was noted with gratitude. With these facilities, all scientific meetings can be held under one roof.

Enhancing the scientific program this year will be five separate color TV presentations. Our sincere gratitude is extended to Smith, Kline and French Laboratories for their willingness to sponsor this excellent and popular teaching mechanism and for bringing their TV staff and equipment to Kentucky for our meeting.

Again, our appreciation goes to the Southern Bell Telephone Company for sponsoring the message center at the heart of the technical exhibit hall. This continues to be a most valuable service to the association and our members.

We would be remiss if we did not also express our deep appreciation to the Scientific Program Committee, which has assembled a most interesting and profitable program, and to the other committees under this council whose accumulative efforts have made this meeting possible. The members of KMA owe the physicians serving on these committees a deep debt of gratitude for the many hours of work that have been contributed toward the success of the 1966 KMA Annual Meeting.

The following reports of the committees serving under the council are herewith submitted:

Recommendations, Reference Committee No. 2

Our Committee studied the report presented by the Council and wishes to commend the Council for its work of many hours in preparing for this year's Associational meeting. We wish to emphasize, along with the Council, the appreciation of the Association to the Smith, Kline, and French Laboratories for their sponsorship of the colored television program and to the Southern Bell Telephone Company for their continued sponsoring of the Message Center.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Scientific Program Committee

Roderick MacDonald, Jr., M.D., Louisville, Chairman

Your Scientific Program Committee met last November to put together our plans for the 1966 Annual Meeting. In addition, we met with representatives of the sixteen specialty groups to explain our plans for the 1966 meeting and the participation of the cooperating specialty groups.

Your chairman, along with KMA staff members, have held countless telephone conversations, numerous personal meetings, and have written an incalculable number of letters in putting this program together.

Five and one half hours of closed circuit color TV, under the sponsorship of Smith, Kline and French Laboratories, Inc., should prove to be an interesting and educational highlight of the 1966 session. We especially express our thanks to the moderators of the TV clinics for their efforts and time in putting together their TV program. In addition to other sessions held, these moderators met twice with representatives of our sponsoring firm to provide you with the best presentation possible.

Our deepest appreciation also goes to the KMA Council on Medical Education and Hospitals. As custodian of the Postgraduate Education Fund, the members of this council agreed to provide the necessary finances to enclose the general assembly area in black polyethylene. This not only will make the color TV more acceptable but adds to the elimination of any noise drift from elsewhere in the convention hall.

One innovation for this year's program has been the establishment of a theme for each one half day general session. We hope this assists in the continuity of the program and proves to be profitable. Otherwise, the format of the program is virtually the same as that of last year.

Your committee continuously strives to present an attractive and educational program, hopefully maintaining the best aspects of past programs and bringing you carefully selected new features.

Recommendations, Reference Committee No. 2

We have read the report of the Scientific Program Committee and realize that much work has gone into the preparation of this year's scientific program. We want to compliment the Committee for its continued improvement in the programs in the past few years and for the very interesting new features which it has introduced.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Golf Committee

James B. Douglas, M. D., Louisville, Chairman

The Golf Committee did not have an official meeting this year as our tournament was scheduled and is planned to be implemented under the policies established for the tournament two years ago.

The Golf Tournament will again be held on one day only, Monday, September 19, affording the golfers a maximum in fellowship and an equal opportunity in the tournament itself. Trophies and other prizes will be presented following completion of the day's activities.

Our usual promotion of direct mailings and articles in the Journal of KMA has been conducted. All applications for the tournament must be submitted to the KMA Headquarters Office by September 1, 1966, along with the members' golf dues for this year so that appropriate plans can be finalized.

It is the committee's desire to present a tournament that is enjoyable to all participants and we solicit any comments on improvements that might be made.

Recommendations, Reference Committee No. 2

We wish to thank the Golf Committee for its continued efforts toward making the meeting one of recreation as well as scientific knowledge and for continuing the golf tournament during non-scientific program hours even when there is inclement weather.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Technical Exhibits Committee

Willett H. Rush, M. D., Frankfort, Chairman

Your committee met at the KMA Headquarters Office on January 13. The committee is charged with organizing and making available a hall in which technical exhibitors may rent space. Revenue from this undertaking applies toward financing the Annual Meeting.

Your committee is not only interested in presenting a technical exhibit hall which is of maximum service to our membership, but is equally interested in serving the technical exhibitor and seeing that he gets his money's worth. With this in mind, the committee examined traffic flow, registration procedures, location of registration desk, and the operation of the message center, very carefully.

In addition to considering these facts, it reviewed with care the report of the Medical Exhibitors Association, which was prepared during the meeting by a liaison committee and submitted to the MEA immediately thereafter. As a result of this thorough review, the committee was pleased to learn of the substantial progress being made and recommends no changes in policy for the 1966 KMA Annual Meeting and the operation of the exhibit hall.

The committee commends the technical exhibit hall to the membership and urges your full support during the annual session. The committee feels that there are few places you can go where there is as much authentic information, where it is as easy to obtain, takes less time, and secured with more ease, than our KMA Technical Exhibit Hall.

The committee wishes to express the Association's appreciation to each of the 75 exhibitors—a record high—for their substantial support of continuing medical education.

Recommendations, Reference Committee No. 2

Our Committee studied the report of the Technical Exhibitors Committee and wish to thank it for its excellent provisions for the technical exhibitors. We also want to thank the exhibitors and encourage all of those present at the meeting to visit the booths and individually express appreciation to those who make our meeting possible.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Awards Committee

William H. Bizot, M. D., Louisville, Chairman

The Awards Committee has promoted the KMA Awards Program throughout this Associational Year through the Journal of KMA, the Communicator, and through mailings to county society secretaries.

This committee routinely meets on two occasions, once during the KMA Interim Meeting to review our plans and accept nominations for awards, and once just prior to the opening of the Annual Meeting to select the recipients. In addition, nominations for awards are accepted throughout the year and distributed to the committee members for consideration.

The awards for which our committee is responsible are the Distinguished Service Award, the Outstanding General Practitioner, and the R. Haynes Barr Award which is for outstanding contribution to the health field by a layman. Citations for these awards will be presented at the President's Luncheon Wednesday, September 21.

Our committee is most grateful for the cooperation we have received.

Recommendations, Reference Committee No. 2

We want to commend the excellent work done by Doctor Bizot and his Committee in the choice of recipients of the outstanding awards and to those of you who have suggested to the Committee these recipients.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Scientific Exhibits Committee

Benjamin B. Jackson, M. D., Louisville, Chairman

The report of the Scientific Exhibits Committee is being submitted in advance of our July 14 meeting so that it can be included in the reports of the Council on Scientific Assembly for early distribution to the Board of Trustees. At our meeting we will review all applications and accept approximately twenty exhibits for the 1966 Annual Session.

Your committee's policy of accepting only those exhibits of truly scientific nature is part of our program to continue to up-grade the quality of exhibits presented. All approved exhibits will be in place by 8:00 a.m. Tuesday, September 20 and are not to be removed until 3:30 p.m. Thursday, September 22.

On Tuesday morning, September 20, a special committee will judge these exhibits and select those which are considered to be the best presentations. All exhibitors will receive a certificate of appreciation and the first place winner will be awarded a $200.00 check and two plaques.

This is the first year a cash award is being made and it along with one plaque is part of the Aesculapius Award Program under the sponsorship of Mead Johnson Laboratories. We are hopeful that this program will increase the involvement of our membership in this important educational activity of KMA.

Members of this committee wish to express appreciation to all physicians who are presenting scientific exhibits this year and strongly urge everyone attending the Annual Meeting to visit these exhibits which are located in the Convention Center in the area between the technical exhibit hall and the scientific sessions.

COUNCIL ON SCIENTIFIC ASSEMBLY
Everett H. Baker, M. D., Louisville, Chairman
Robert E. Pennington, M. D. London, Vice Chairman
Harvey Chenault, M. D., Lexington
Benjamin B. Jackson, M. D., Louisville
Roderick Macdonald, Jr., M. D., Louisville
Edmund D. Pellegrino, M. D., Lexington
Willett H. Rush, M. D., Frankfort

Recommendations, Reference Committee No. 2

We have evaluated the report of the Scientific Exhibit Committee as submitted and want to accept their report with the suggestion that in the future when monetary awards are available for first place winner that in order to stimulate greater participation that awarding of plaques be made to second and third place winners.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Council on Medical Education and Hospitals

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the bylaws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Education and Hospitals is presented in the following order:

1. *Actions and recommendations by the council which it undertook on its own initiative.*
2. *Reports of the committees of this council with the council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Medical Education and Hospitals has met three times during the associational year—May 26, 1966, March 23, 1966, and December 2, 1965.

At its first meeting, the members of the council discussed the activities of the committees serving under the council and their future plans. Committees serving under the council are: Advisory Committee to the University of Kentucky, Advisory Committee to the University of Louisville, AMA-ERF Committee, General Practice Committee, and Hospital Committee.

Additionally, the council reviewed matters that had been approved by the KMA House of Delegates at its Annual Meeting and other matters of interest approved by the AMA House of Delegates at the June 1965 Annual Meeting and November 1965 Clinical Meeting. We also discussed on request a program established by the Daniel Boone Clinic whereby a certain amount of funds would be provided to a student during his junior and senior years in medical school and during internship providing the student signed a contract saying he will be an employee of the Daniel Boone Clinic for an equivalent period of time. This matter was referred to the Board of Trustees and Judicial Council.

The main items discussed at the second meeting of the council were: State-wide Hospital Planning; a Critique of the Park Mammoth Medical Education Conference and a recommendation approved by the Board of Trustees that such a conference be held every other year; and a detailed discussion on PL 89-239 (Heart, Cancer, Stroke Amendments—1959) which was referred to the council by the Executive Committee. Donn L. Smith, M. D., Dean, University of Louisville School of Medicine, gave a detailed report on this program, which follows.

Excerpts from KMA Council on Medical Education and Hospitals

Report—PL 89-239

It was explained that PL 89-239 has been investigated by deans of eight medical schools: Western Reserve, Indiana, Ohio State, Pittsburgh, West Virginia, Cincinnati, Kentucky, and Louisville.

It was pointed out a representative from the Greater Cincinnati Hospital Planning Council furnished data in the deliberation of what would make a region and didn't make a region, and was further pointed out that the deans who were meeting together decided they had several regions represented in their meetings. The deans discussed the pros and cons of various parts of the program and after consideration of some of the data, it became apparent that as a single regional operation, it was entirely too large, and several regions could be formed. It was felt that the University of Louisville School of Medicine, the University of Kentucky Medical Center, and the University of Cincinnati Medical School would make a very natural unit.

It was noted that all of this preliminary work was simply to prepare the deans to have a meeting with Robert Q. Marston, M. D., Chief, Division of Regional Medical Programs, National Institute of Health, who took over his new assignment shortly after the first of February. A very productive discussion was held with Doctor Marston regarding advisory committees, clarification on size of regions and possible conflicts arising from too small a region versus too large a region, and plans from other parts of the country.

One of the basic points brought out in the Washington meeting is that the best way to handle this law is to have a planning group per region. The deans had considered having an umbrella planning group for these regions to be broken down on an operational basis, but finally decided that this should be set up on a regional basis for planning purposes.

It was pointed out that none of the deans in the three schools involved (U of L, U of K, and UC) have any authority from their schools to proceed with implementation but they are acting on an exploratory basis. It was also noted that Russell Teague, M. D., had expressed an interest in the participation of the program for the Department of Health. If it turns out to be a three-school region, there will have to be cooperation between the Kentucky and Ohio Departments of Health, both of which must have someone on the Advisory Committee; otherwise, it will not be able to function properly.

It is apparent that if UL, UK, and UC go together as a region there will have to be representatives from both the Kentucky and Ohio Health Departments, Jefferson County, Fayette County, and the Cincinnati Medical Society, Kentucky and Ohio Heart Associations, Cancer Association, nursing profession, hopsital administrators, probably the dental people and then a fairly substantial group of lay people. If there is too large an Advisory Committee, an Executive Committee within the Advisory Committee will have to be appointed. It was felt that the formation of the Advisory Committee will be the hardest part of this organization.

It was explained that the three deans involved in the proposed region are favoring a slow approach and think that initial activity will be built around continuing education. One of the big advantages in having UC in the region is getting data for medical resources.

It was noted that ideally there should be a region composed of Indianapolis, Cincinnati, Louisville, and Lexington; but indications are that Indiana wants to go in as a single state. It was stated that the planning will be fairly comprehensive and fairly expensive, since there will be a three-school hook-up involving 3.4 plus million people. It was noted that there have been no definite moves made, everyone is treating this with caution, and that it will become urgent that a basic organization be set up in the very near future.

School deans stated it is fairly apparent that government will look at this on a population basis and that the government will not consider a population basis of less than 2.5 million people which makes it more apparent that the region will consist of UK, UL, and UC.

It was pointed out also: (1) that this program will make possible a vast opportunity in the research areas in medical care; (2) that the medical profession is going to have to face some changes along this line; and (3) this will give an opportunity to explore these areas in a way that is acceptable to medicine instead of waiting to be told how to do it; (4) this is an opportunity that the medical profession should grasp—particularly the areas of continuing education.

* * * *

At its last meeting, the council was brought up-to-date on the use of postgraduate education funds; discussed services available to the University of Louisville School of Medicine Library; selected the 1966 Faculty Scientific Achievement Award recipients; and took final action on Resolution K entitled, "Private Use of Medical Students as Physicians for Hospital Profit," which was referred to the council by the 1965 House of Delegates.

In considering the above it was recommended that the council authorize the Board of Trustees to use postgraduate funds in certain instances in connection with future KMA Annual Meetings and specifically during the 1966 Annual Meeting to purchase polyethylene curtains for the purpose of enclosing the general assembly area so that color TV could be presented. The council makes note that while it reports to the Board of Trustees, this authorization is deemed appropriate since the council is the sole agent of the Postgraduate Educational Funds. We recommend to the KMA Journal editorial staff that the University of Louisville School of Medicine Library services available to the physicians in the state be made known to them through articles in the Journal and the Communicator and further that various hospitals in the state, through their library or hospital administrators, be made aware of the services so that this service can be disseminated to the staff at this level; we also recommend that the KMA House of Delegates not adopt Resolution K. This council investigated the background of this resolution and is providing the reference committee with copies of Resolution K referred to us by the 1965 House of Dclegates along with information collected to support our recommendation.

The report of the committees covering their activities and recommendations follow.

Recommendations, Reference Committee No. 2

We have reviewed the report of this Council regarding its meetings and the various items considered and wish to accept the Report except as noted below. (General Practice Report)

Mr. Speaker, I move the adoption of this section of the report.

(The motion was seconded and carried.)

Advisory Committee to the University of Louisville

George A. Sehlinger, M.D., Louisville, Chairman

and Advisory Committee to the University of Kentucky

Andrew M. Moore, M.D., Lexington, Chairman

(Joint Report)

The Advisory Committee to the Louisville School of Medicine and the University of Kentucky College of Medicine met jointly during the associational year on January 6, 1966.

Members of the committee reviewed their report to the 1965 House of Delegates which dealt in most part with the medical questionnaire developed by the KMA Council on Medical Education and Hospitals to study and improve the "Town and Gown" relationship. In conjunction with this, we discussed the Conference on Medical Education which was held at Park Mammoth after our committee meeting. It was the opinion of the committee members that such meetings are generally beneficial in that they lean toward better understanding of the two medical schools and KMA.

The committee was brought up-to-date on the 1965 AMA Clinical Meeting held in Philadelphia. Members discussed and received for information three AMA Reports: Report A—Revision of Essentials for an Agreed Curriculum in Occupational Therapy; Report B—Revision of Essentials for an Acceptable School of Medical Record Technicians, both of which intended to update the minimal education standards for the two groups, and Report C—Critique of the Coggeshell Report, "Planning for Medical Progress Through Education." Report C. received considerable discussion from the standpoint of the role universities will eventually play in medicine and this effect on medicine of the future. It was the concensus that all KMA Members should read the document and become aware of the many points made therein.

We reviewed Resolution K—Private Use of Medical Students as Physicians for Hospital Profit, which was introduced at the 1965 KMA House of Delegates. Considerable discussion was held on this resolution and members of the committee had planned to receive a report on this matter at their second meeting. Due to our inability to obtain a quorum for a second meeting, your chairman referred the report to the Council on Medical Education and Hospitals for information and possible recommendations.

We find it very rewarding and beneficial for the two advisory committees to meet jointly and recommend they continue to do so in the future.

Recommendations, Reference Committee No. 2

We have read the report of this Committee which met jointly this year and at our Committee meeting heard reports of gratitude from the Medical School at the University of Kentucky for the work of this Committee. Since it seems to the mutual benefit of all that the two Committees meet jointly, we concur in the recommendation that they continue to do so in the future.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

AMA-ERF Committee

Walter I. Hume Jr., M.D., Louisville, Chairman

The AMA-ERF Committee of the KMA met on April 27, 1966, and discussed the four year's progress of this concept at a national and at a state level. It was pointed out that the program functions very well at a national level and that this has in the past somewhat blunted our efforts to do a great deal at the state level for this purpose. The members present, however, recognizing that this is a very valuable program from the point of view of direct results attained, and also from the point of view of public relations, suggested that we be somewhat more active in the state, and this activity take the form of an increased level of publicity for the program. We propose to suggest the following:

1. An editorial on the subject in the KMA Journal,
2. Monthly short notices in the KMA Journal throughout the year,
3. An information letter to county medical societies suggesting promotion at county medical society meetings,
4. Brief notices about the progress of the program in the KMA Communicator twice a year, and
5. Work with the KMA Woman's Auxiliary AMA-ERF Committee, possibly with the aim of staffing a booth at the KMA Annual Meeting.

These suggestions are in progress of being worked out.

During the Interim Meeting in April, checks were presented from this fund to the Dean of the University of Kentucky College of Medicine for $4,178.18 and to the Dean of the University of Louisville for $8,981.02. In addition, during 1965, 206 loans were made to medical students, interns, and residents in this state in an amount totaling $241,000—an increase of over $22,000 since 1964.

This program has been most successful in its national aim of making loans available to medical students, interns, and residents, making some unrestricted funds available to the various medical schools, and it is, with the introduction of the new Institute for Biomedical Research, now introducing its influence into the research field even more strongly.

We on the committee appreciate the support of the physicians and the Woman's Auxiliary in Kentucky for this program, and encourage your continued and increased contributions in the future.

Recommendations, Reference Committee No. 2

We have studied the report of this Committee and its plan for future promotion. We want to compliment the Committee and encourage greater participation by all physicians in Kentucky in this worthy project as well as the encouragement given it by the Kentucky Medical Women's Auxiliary.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

General Practice Committee

Robert M. Sirkle

The General Practice Committee met at the Kentucky Hotel in Louisville on Wednesday, May 11, 1966. The committee reviewed its assigned duties, its 1965 report to the House of Delegates and its relationship to the Council on Medical Education and Hospitals.

Resolution 49, introduced by the Michigan Delegation to the AMA House of Delegates at the 1965 Clinical Meeting, was brought to our attention and this committee endorsed the action of the AMA House of Delegates on this resolution. This action was to "reaffirm and again communicate to all members of the American Medical Association and through the AMA representatives to the JCAH that all doctors of medicine, regardless of their field of practice, should be accorded hospital privileges commensurate with their training, experience, and demonstrated competence on approval by the medical staff."

The Kentucky Chapter, American Academy of General Practice, Congress of Delegates, in session on May 10, 1966, approved a resolution which in part states as follows:

> "RESOLVED, That the Kentucky Chapter of the American Academy of General Practice insist that by July 1, 1966, the needy, as defined in Title 19 of Public Law 89-97, receive at least the same care coverage as the recipients of Title 18 of the same law for the five basic services as well as dental care, drugs, home nursing care, prosthetics, rehabilitative services, physical therapy, and eye glasses. Be it further
>
> RESOLVED, That fees for Physicians be based solely on usual, reasonable, and customary fees for services rendered. Be it further
>
> RESOLVED, That this be presented and supported vigorously to the KMA House of Delegates for its implementation."

This committee recommends to the KMA House of Delegates approval of the above statement by substituting the words "Kentucky Medical Association" for "Kentucky Chapter of the American Academy of General Practice" in the first resolve.

(The above resolution and the paragraphs immediately preceding and following it, were referred to Reference Committee No. 5.)

Your committee discussed at length a physician education program in psychiatry to be sponsored by the American Academy of General Practice and the American Psychiatric Association for general practitioners. No definite recommendations are being made concerning participation in this program in Kentucky. However, this committee plans to maintain liaison with the KMA Mental Health Committee concerning these proposed workshops in psychiatry and expresses favor in the planned program.

Following a discussion of the recommendation this committee made last year relative to the establishment of Departments of Family Practice in Kentucky's two medical schools, this committee recommends that the KMA Council on Medical Education and Hospitals study the possibility of using qualified general practitioners on the faculties of the medical schools and regional complexes.

We discussed the proposed project of the University of Kentucky College of Medicine whereby medical students may be invited to spend one week in a physician's office during the summer months to study the content of a family physician's practice. This committee recommends that Kentucky physicians in general practice consider participating in this program.

The committee members again expressed interest in seeing a listing or directory of Kentucky physicians designating each physician's type of practice. We understand that such a directory is being issued in the near future by the State Department of Health and is also under study by KMA.

Health Insurance Claim forms to be used in connection with Medicare were distributed and reviewed by the committee members.

COUNCIL ACTION: It is recommended by the Council on Medical Education and Hospitals that the report of the General Practice Committee be accepted as presented with the following notations: In reference to the resolution adopted by the Kentucky Chapter of the Academy of General Practitioners Congress of Delegates in session on May 10, 1966, and as recommended by the General Practice Committee, the members of this council found themselves in sympathy with the objectives of the resolution, but felt that it did not fall within the charge of this council; therefore, it is being referred to the Board of Trustees for appropriate disposition. In reference to the recommendation made by the committee in regard to the possibility of using qualified general practitioners on the faculties of the medical schools and regional complexes, the council noted that this matter has been studied in the past and has been discussed during the past year and it is under continuing review.

Recommendations, Reference Committee No. 2

Except for Paragraph 3, bottom of Page 6, Report No. 12 through Paragraph 3, Page 7, Report No. 12, which was referred to another Committee, we have noted the various comments of the General Practice Committee regarding desirable programs of continued education and outlines of general practice cooperation with the medical schools and recommend the acceptance of the report as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

The Hospital Committee met three times, on November 18, 1965, March 31, 1966, and May 18, 1966, and all meetings were well attended. In addition, the Hospital Sub-Committee to Study Resolution A, referred from the Executive Committee, has

met a number of times with members of the KHA. Resolution A entitled "Administrative Relationship Between Hospitals and Private Practitioners of Medicine Practicing Within Hospitals" was approved by the House of Delegates in 1965. Indeed, the problem of Resolution A has been the Hospital Committee's major problem this year. As matters stand, the report on Resolution A is as follows:

1. The radiologists can make an ethical contract, with the wording to be worked out by the individual radiologists. This committee suggests that the radiologists follow the advice of Mr. Gaines Davis, KMA Legal Counsel.

2. At the present time, there seems to be no feasible way for the pathologists to make an ethical contract with the KHA as a whole. There is notable exception in Ashland. It was apparent to the members of this committee that the KHA was attempting to split the clinical laboratory from the anatomical laboratory.

Should any changes come about prior to the September KMA meeting, an addendum will be posted.

A discussion of area-wide planning has occupied a great deal of the committee's time and the chairman of the committee has met on a number of occasions with the Executive Committee, the KHA, and The Council on Medical Education and Hospitals. Various plans to work on area-wide planning have met with opposition, indifference, or unenthusiasm. Unfortunately, we have not been able to really generate interest in enough influential people, either lay or medical, to develop a concensus on just where the Kentucky Medical Association's part is in area-wide planning. Specifically, the objections to a state group are many because of the size and the complexity of our state's geography. Interest in any educational seminars is somewhat curtailed by a lack of funds. Attempts to divide the state into area-wide planning groups either larger or smaller or different to that envisioned by the State Department of Health meets with varying degrees of opposition depending on one's geographical location and ideas of empire. At its last meeting, the committee agreed to table work on regional area-wide planning until more interest is shown.

Other important items considered by the committee members and action taken are as follows:

1. A continued study of the ARHI Hospitals was made and there were no specific developments except that there is a good possibility that Middlesboro offices will be built outside the hospital within a year.

2. Discussion of a central clearing house for medical records so that small hospitals might review records other than their own has been tabled because of lack of interest on the part of the small hospitals.

3. Dry-Run Teams have continued to receive requests and to make inspection visits to a number of hospitals.

4. The Emergency Room Pamphlet has been approved and should be under distribution soon.

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS
George A. Sehlinger, M.D., Louisville, Chairman
James B. Holloway, M.D., Lexington
Walter I. Hume, Jr., M.D., Louisville
Andrew M. Moore, M.D., Lexington
Donn L. Smith, M.D., Louisville
William R. Willard, M.D., Lexington
William P. VonderHarr, M.D., Louisville

Recommendations, Reference Committee No. 2

We studied the somewhat lengthy report of the Hospital Committee, including the addendum with reference to the discussion of progress made thus far in the realm of area medical centers. Our Committee approved the report and suggests a continued effort on the part of the Kentucky Medical Association in the area of regional hospital planning.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was seconded and carried.)

Resolution E

Muhlenberg County Delegation

Whereas, The accumulation of knowledge gathered by the utilization review committees is of such great value in the improvement of the overall medical care of the population at large, and

Whereas, The Joint Commission revised the Standards for Hospital Accreditation in Bulletin #40 (December 1965) to make the performance of utilization review function one of the requirements for Accreditation, and

Whereas, A fair and impartial comparison between the standards of care, length of stay and cost of treatments of various disease entities as determined by utilization review committees in state or federally controlled hospitals as opposed to voluntary nonprofit community and proprietary hospitals might be of great value to government officials (both appointed and elected) in their future deliberations relative to government involvement in Medical Care, and

Whereas, The Metropolitan Insurance Company and Blue Cross has been designated by the Social Security Administration (federal government) and the governor's Advisory Council has been designated by the State Government to formulate and suggest plans to implement Public Law 89-97 in Kentucky; now therefore be it

Resolved, That accredited governmental, voluntary community non-profit and proprietary hospitals at all levels in Kentucky (including Veterans Administration Hospitals but excepting Military Hospitals handling service personnel on active duty) be required to establish active utilization review committees with participation of staff members and representatives of local county medical societies, and be it further

Resolved, That the results and reports of these utilization review committees be made available to the aforementioned agencies concerned with utilization efforts under Public Law 89-97 in Kentucky for purposes of review and comparison, and be it further

Resolved, That the results of this comparison be made public in an annual report by these agencies.

**Refer to Resolution #24 adopted at June 1966 A.M.A. Meeting in Chicago.*

Recommendations, Reference Committee No. 2

We have studied the Resolution as presented by the Muhlenberg County Delegation and recommend it as presented. We believe that the ingredients of this Resolution are embodied in the report of the Hospital Committee which you have already adopted.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was seconded and carried.)

Resolution M

Barren County Medical Society

WHEREAS the present trend of accreditation of hospitals is to bring all accreditation of medical services under one agency; and

WHEREAS the mechanics of and the facilities for giving quality medical care differ radically in teaching hospitals, state hospitals, large and small hospitals and nursing homes; and

WHEREAS there is an impending danger of centralizing all medical services in hospitals; and

WHEREAS there is great peril of the physicians losing their professional identity and losing their professional freedom; and

WHEREAS there is a great possibility of all hospital medical staff members being reduced to the status of hospital employees; and

WHEREAS there is an inherent danger that stereotyped and unnecessary rules of standardization of physicians' and ancillary medical services in the hospital will tend to cause some hospitals to lose the financial support of governmental and some private agencies; and

WHEREAS local hospitals are being asked to surrender their independence of the control of medical services to outside agencies not under the control of physicians; and

WHEREAS the control by such outside agencies and groups is against the best interests of the hospital and the physicians in rendering quality medical care to their patients and to their communities; therefore,

RESOLVED that the KMA appoint an Ad Hoc Committee of thirteen members to study the feasibility of and to set up the mechanics for accreditation of physicians' and ancillary medical services in the hospitals of Kentucky by the KMA.

RESOLVED that this committee be composed of thirteen members—a chairman, two members from teaching hospitals, two members from state hospitals, two members from staffs of hospitals of towns with a population of 10,000 or less, two members from staffs of hospitals of towns with a population of 10,001 to 30,000, two members from hospital staffs of towns with a population of 30,001 to 70,000 and two members from hospital staffs of cities with a population of 70,000 or more.

September 6, 1966

Recommendations, Reference Committee No. 2

Our Committee heard considerable discussion on this Resolution presented by the Barren County Medical Society regarding the desire for physicians' control of accreditation of Kentucky Hospitals. We believe that a feasibility study such as this is desirable.

Mr. Speaker, I move the adoption of this section of the report. (Motion Seconded; carried.)

Mr. Speaker, I move the adoption of Reference Committee No. 2 as a whole. (The motion was seconded and carried.)

I wish to thank Eugene Conner, M.D.; James A. Harris, M.D.; Robert J. Salisbury, M.D.; and J. Sankey Williams, M.D., members of this Committee and Miss Liza Hancock for her assistance in preparation of this report.

REFERENCE COMMITTEE NO. 2
Eugene Conner, M.D., Louisville
James A. Harris, M.D., Paducah
Robert J. Salisbury, M.D., Mt. Sterling
J. Sankey Williams, M.D., Nicholasville
Paul J. Porks, M.D., Bowling Green,
Chairman

REFERENCE COMMITTEE No. 3†

Carl Cooper, M.D., Chairman

Reports on Legislative Activities

See note (†) bottom of column one, page 1122.

Reference Committee No. 3 considered the following:

13. Council on Legislative Activities
(National and State Affairs)

Resolution H—Direct Billing, Title XIX

Report of the Council on Legislative Activities

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Legislative Activities is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committee of this Council with the Council recommendation following the committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

National Affairs

John C. Quertermous, M.D., Chairman

The Legislative Council during this associational year met six times. The Chairman and the members of the Council and Committee have attended other important meetings in other cities on matters pertaining to national legislation.

It is not believed that it will be necessary for the Council to expend as much effort in the coming year as has been necessary in the past, since the Congress and most of the people of the United States are showing signs of being appalled by the magnitude of the havoc wrought by the passage of P.L. 89-97 and P.L. 89-239. This, plus other ill-conceived programs of the "Great Society" coupled with the war in Viet Nam, will certainly create in congress the tendency to look more closely at other socialistic programs before they give their approval.

The Washington Dinner was again felt to be worth the money and effort expended by the Association. The Council believes our rapport with our legislators to be excellent in almost all cases, and it is apparent that the trip to Washington over the past number of years has enabled the representatives of the Association to have an easy and effective relationship with our representatives in Washington. The Council recommends that it be continued.

The Council has contacted our legislators personally, by letter and by wire on several occasions pertaining to bills on antivivisection, physician retirement, use of generic terms in prescribing, as well as to try to determine from them their ideas pertaining to the most effective method to combat further inroads by government into the private practice of medicine.

The Legislative Council recommends that KMA endorse the action of the AMA House of Delegates of 1966 in Chicago in recommending an option of choice of billing by the physician under Title XIX, which parallels the optional choice of billing under Title XVIII. We further recommend that all members of the Kentucky congressional delegation be informed of our action and that they be asked immediately to introduce the necessary amendment or amendments to implement this endorsement, and that they work diligently for the passage of such legislation.

The Legislative Council further recommends that the House of Delegates of KMA reiterate KMA's

support of the individual voluntary physician-patient relationship and the fee for services concept.

Over 90 physicians participating in the KMA Legislative Key Man System attended an orientation meeting in Louisville on January 12, 1966. At this meeting, all key men were provided with a newly designed and completed Key Man Booklet. The statewide physician team had outlined to them the responsibility of those in the system at both national and state levels.

The Legislative Bulletin was published regularly during the 1966 Session of the Kentucky General Assembly and frequent use of it is made during the year to inform our members of important pending national legislation. This is a valuable publication mailed to KMA officers, key men and county medical society secretaries, and it is recommended that the information be used for a basis of discussion at county society meetings.

The Council reaffirms its belief in the objectives of KEMPAC and AMPAC and recommends 100% participation by doctors and their wives. We also recommend to the House of Delegates that there be county society billing in order to encourage this participation, and we finally recommend a vote of endorsement and encouragement by this House of Delegates of the KEMPAC organization to continue its worthwhile political efforts in the behalf of our free enterprise system and the freedom of the art and science of medicine.

Special thanks to Mr. Joe Sanford and the KMA staff for their contributions to this Council during the past associational year. Their assistance in both state and national legislative affairs has been most noteworthy and very much appreciated. Our Director of Field Services, Mr. Gilbert L. Armstrong, spent much of his time during the first few months of 1966 in Frankfort as our lobbyist, and we would be remiss without reporting to you the very fine service he rendered in this capacity.

We would like to express our appreciation to the members of this Council for their unselfish contribution to the Association. We especially want to pay tribute to two of our hard working members, David B. Stevens, M.D., Lexington, and Gabe A. Payne, Jr., M.D., Hopkinsville, who have found it necessary to resign their membership from the Council because of other pressing matters. Their efforts during the past year and previous years have been appreciated by other members of the Council and most beneficial to our Association.

We sincerely congratulate Doctor Payne on his recent appointment to the Kentucky State Board of Health. He joined B. B. Baughman, M.D., Frankfort, in being the second member of the Council serving in this important capacity. We sincerely regret Doctor Payne's subsequent resignation from the Council.

Two new Congressional Key Men were appointed during the year: Faxon W. Payne, M.D., Hopkinsville, to serve the First District and Andrew M. Moore, M.D., Lexington, for the Sixth District.

Recommendations, Reference Committee No. 3

This committee wishes to commend Doctor Quertermous for his work as Chairman of the Legislative Council, especially for his presentation in the report of the many activities which have been carried out in national affairs.

We also concur that the Washington Dinner should be continued. It is recommended that the House of Delegates reiterate KMA's support of the individual voluntary physician-patient relationship and the fee for service concept.

We commend the KMA Legislative Key Man System and wish to take this opportunity in thanking all legislative key men throughout the state. We wish also to commend KEMPAC and its objectives and recommend 100% participation by all doctors and their wives.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried)

State Affairs

J. Campbell Cantrill, M.D., Chairman

Since our last report to the 1965 Session of the House of Delegates, the Legislative Council has experienced one of the busiest and most frustrating years in the history of the Kentucky Medical Association.

With all due respect to the other loyal and dedicated councils of the KMA, we honestly believe that the Legislative Council has been the most operative, not by choice, but by compulsion, due to the 1966 Kentucky General Assembly in Frankfort. At the very outset, I wish to relate to the members of the House of Delegates that I am exceedingly proud of each and every member of our Council for the dedicated and tireless efforts that they have contributed to the Kentucky Medical Association during the past year.

The Headquarters Staff was literally deluged with extra work, telephone communications, additional secretarial and lobbying assistance. We would like to report to this House that the effectiveness of Mr. Gilbert L. Armstrong, our field representative and legislative specialist in Frankfort, was unsurpassed by any single group of legislative specialists representing any other organization.

The KMA Legislative Key Man System, which has arisen from its embryological stage, has now begun to reach maturity and has born forth fruit. Each key man in this system has worked effectively and loyally, and we feel that with further training as a team that we will develop a more effective legislative organization in the future.

The Legislative Council has met on numerous occasions during the past year: in the Headquarters Office of the KMA; in Frankfort during the actual session of the General Assembly; in Washington, D. C., at the Washington Congressional Dinner; and a quorum was present at the recent convention of the American Medical Association in Chicago in July.

Your Chairman for State Affairs attended the AMPAC Seminar in Washington in May of this year, and several members of the Council did attend the AMA Council on Quackery in Chicago. Doctor Quertermous has already alluded to the very successful meeting of the Legislative Key Men Orientation Seminar in Louisville in January of 1966. All of these activities have involved lengthy study sessions on the part of the physician members of the Legislative Council in order to be prepared for each of these legislative meetings involving pending legislation in Washington and Frankfort. These physician members of this Council and the Key Men, Mr. Speaker, have worked diligently and sacrifically for this Association, and I would like to acknowledge publicly to this House of Delegates that I am proud to be a member of such an organization. Never have we had such support from the Board of Trustees, and especially the Executive Committee of the Board of Trustees, and also from the strong and forceful leadership of President Everett Baker, M.D.

It has been pointed out in the Legislative Bulletins that during the recent General Assembly that 10% of all the legislation considered involved health legislative matters. Let us hasten to add, that whereas certain pieces of legislation which were acted upon and listed on this tally sheet, there were many other pieces of legislation which were proposed, and were kept from coming to the surface by our legislative efforts. For example, certain aspects of Title XIX did not arise in Frankfort as they did in the state of New York under the observant eyes of Governor Rockefeller. In retrospect, maybe this item should have arisen at that time. We were extremely lucky that

many other pieces of medical legislation did not arise from the mire during the recent session.

Therefore we feel that it is mandatory that the Legislative Council, including the Key Men at all levels renew their efforts in the future to be alert to the possible dangers which will arise by the incredible mass of health legislation that is now engulfing us. One of the ways which we think that our effectiveness can be improved, and this is not a new petition, is for every physician in the state to become acquainted with his legislator before the General Assembly meets. Our candidate support should begin before the Primary. That support can be either financial, social or political. The legislators have been very candid in their criticism of the physicians for their lack of Pre-Primary support. You do not obtain support from the legislator when you are requesting his assistance approximately thirty minutes before an issue is to be voted upon in the halls of the General Assembly. This could be avoided if each county medical society had a legislative or physician committee of its own, where the candidate could be invited to speak and discuss his legislative philosophy. Thereby, the physicians could learn his stand on possible previous commitments and familiarize themselves with his political philosophy and his previous voting record. This information could be disseminated to the Key Men and then to the Legislative Council for further action and study. How effective this Association could be if at the time the Legislature convenes, the physician could already be "friends" with his legislator and come to the legislator "not as a stranger".

The Council noted the independent action of certain specialty groups and individual physicians of the Association who were working for their own specific interests. Some of these pieces of proposed legislation were confused, and the Legislative Branch of the KMA was unaware of their existence. As a result, chaos reigned—the legislators were confused—ill will was created—and certain major proposals that this House of Delegates had recommended went down to defeat. All proposed legislation should be communicated through the Legislative Council and to the Board of Trustees in a clear, concise, legal manner in order that medicine will create a unified and coordinated effort on all pieces of medical legislation.

One of the most important lessons learned in the recent General Assembly was that the individual legislators respected a forceful and aggressive approach in a unified manner to any proposed piece of legislation. Positions of compromise and appeasement will produce no image other than that of extreme weakness.

Diplomacy, yes—but not appeasement! Four thousand years of history have taught us this basic truth. We feel that it is time that the physicians develop a clear concept of legislative proposals and go forth with a positive, aggressive and countering legislative program which has the unified support of the KMA and the AMA. Those are our duties as outlined in the constitution of the KMA. It is indeed gratifying to see the physicians of this state and of this country now acting and reacting against abhorrent medical legislation which has been passed by the federal and state governments. In spite of the results of the action of the Kentucky Governor's Advisory Council on Medical Assistance at its open hearing in Frankfort in July, it was most reassuring to see all the physicians of the state, both specialists and non-specialists, pleading their cause in unison. Let the physicians be reminded that the motion of our chairman, John C. Quertermous, M.D., who represented the KMA at this meeting, died for lack of a second. Your Council feels that this is further evidence that organized medicine will have to fight its battles alone.

1. The Legislative Council wishes to express to this convention that there is a dire need for additional staff legislative specialists in Frankfort during the General Assembly. It is utterly impossible for one staff legislative specialist to cover both houses of the legislature at all times during the day and night. With the magnitude of the job before us, it is unfair to expect one staff legislative assistant to execute all our legislative wishes. The Council further feels that it is incumbent on more physicians to enter the political arena for our salvation. The trail in this direction has been blazed by Mitchel B. Denham, M.D., Tim Lee Carter, M.D., Durwood Hall, M.D., et al.

2. A permanent Sub-Committee on Cults has been appointed by the Board of Trustees, which will continue its work throughout the year under the able leadership of David B. Stevens, M.D., Michael R. Cronen, M.D., and Jesse Tapp, M.D.

3. With the defeat of the so-called "Coroner Bill" in the last legislature, it is our intent to restudy this proposal and develop more concrete and clear-cut legislation to present to the next legislature. It is most important that some type of legislation in this field be passed.

4. We intend to continue the fight against all forms of quackery in this state, and to see that our new anti-advertising law is rigidly enforced.

5. Our basic philosophy continues to be reinforced in that we will continue to struggle for the maintenance of the voluntary doctor-patient relationship and for the freedom of medicine in this country from complete governmental control. This includes any form of interference by third parties. Our fees should be usual, customary and reasonable. In this way only can we preserve our medical liberty for us and for our patients.

We would also like to express our profound appreciation for the two supporting editorials in the Journal of the KMA, written by Sam A. Overstreet, M.D., and Walter S. Coe, M.D. These editorials alone have prevented an acute reactive depression of the members of the Legislative Council, and we sincerely appreciate this public acknowledgment and support of the Council's efforts.

Recommendations, Reference Committee No. 3

This committee wishes to commend Doctor Cantrill for his untiring efforts and dedication to the causes of legislation for the Kentucky Medical Association at the state level.

As pointed out in Doctor Cantrill's report, there is a dire need for additional legislative specialists in Frankfort during the Kentucky General Assembly. We strongly recommend that the services of such an additional legislative specialist be procured for this purpose.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried)

Report of the Sub-Committee on Cults

David B. Stevens, M.D., Lexington, Chairman

The first meeting of the Sub-Committee on Cults was held in conjunction with the KMA Interim Meeting at Cumberland Falls on April 14, 1966. Present were: David B. Stevens, M.D.; Michael R. Cronen, M.D.; and Jesse Tapp, M.D.

Discussion was held concerning possible programs for the Committee. Areas of interest included legislative, legal, professional and public education and coordination of state activities with the AMA Committee on Quackery.

It was agreed that this Committee would have an AMA Committee on Quackery exhibit at the KMA Annual Meeting, staffed by Robert Youngerman. Future plans are to pursue the other objectives and activities previously initiated.

Recommendations, Reference Committee No. 3

This committee wishes to commend the Sub-Committee on Cults for its activities and urges continuing work in this area.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried)

KMA COUNCIL ON LEGISLATIVE ACTIVITIES
Branham B. Baughman, M.D., Frankfort
Hoyt D. Gardner, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
John C. Quertermous, M.D., Murray, Chairman, National Affairs
J. Campbell Cantrill, M.C., Georgetown, Chairman, State Affairs

Resolution H

Fayette County Medical Society

WHEREAS, the direct billing technique for Title XIX recipients was endorsed as American Medical Association policy at the 1966 Annual Meeting and by the Board of Trustees of the Kentucky Medical Association, and

WHEREAS, this has not been implemented in the State of Kentucky, therefore be it

RESOLVED that the Legislative Council of the Kentucky Medical Association make personal contact as soon as possible with the American Medical Association Washington Office and the Kentucky Congressional Delegation to obtain enabling federal legislation, and be it further

RESOLVED that appropriate Kentucky Medical Association committees, as directed by the Board of Trustees, begin negotiations with the State Agencies, (Department of Health and Department of Economic Security) to obtain this optional mechanism of physician payment in Kentucky at the earliest possible time.

Recommendations, Reference Committee No. 3

This resolution was referred to Reference Committee #3 and was duly considered:

Mr. Speaker, I move the adoption and implementation of the report. (Motion seconded and carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 3 as a whole.

As chairman of Reference Committee No. 3 on Legislative Activities, I wish to thank the members of my committee for their assistance, and the people who appeared before the committee.

REFERENCE COMMITTEE NO. 3
David A. Hull, M.D., Lexington
W. Faxon Payne, M.D., Hopkinsville
James C. Salato, M.D., Columbia
Carl Cooper, M.D., Bedford, Chairman

(Charles E. Peck, M.D., Russell Springs, a member of this Reference Committee, sent word that he would be late. He was unavoidably detained and did not arrive in time for the meeting. For this reason, a replacement was not obtained.)

REFERENCE COMMITTEE No. 4†

Fred C. Rainey, M.D., Chairman

Reports on Public Service and Allied Professions

See Note (†) bottom of column one, page 1122.

Reports considered by this committee were:

15. Council on Communications and Public Service
14. Council on Medical Services, page 14, first full paragraph thru page 15, and supporting material
16. Council on Allied Professions and Related Groups with the Exception of page 2, starting at the beginning of the second paragraph top of page 2 and ending with the paragraph at the top of page 3—also, "Board Action" bottom of page 43 and addendum of TB Committee after page 44, which was referred to Reference Committee No. 5; and page 14, paragraph 2, which was referred to Reference Committee No. 6.

Resolution D

Report of the Council on Communications and Public Service

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the Bylaws, which reads in part:

" . . . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Communications and Public Service is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

The Council on Communications and Public Service has called two meetings during this associational year, on December 16, 1965, and July 7, 1966.

We have continued throughout the year to promote KMA's public service programs, health education, careers in the health fields, and generally strived to fulfill our duties as outlined in the Bylaws of the Association.

Our first meeting was primarily designed to discuss the activities of the committees serving under this council and to assist in planning their programs for the 1965-66 associational year as well as the plans of the council itself. In addition, we reviewed our activities of the previous year along with the action taken by the House of Delegates on our recommendations and similarly reviewed programs and policies of the AMA which were within our realm of interest.

One of the prime purposes of our second meeting was to take appropriate action on the final reports being submitted by the committees reporting to this council. In addition, we held a thorough discussion on the health education exhibits we have presented each year at the Kentucky State Fair and the Annual Meeting of the Kentucky Education Association. Approval of exhibits for these two occasions for the year 1967 will be a part of our agenda at the fall meeting. At the State Fair in August of this year, we will present a 16-foot exhibit entitled, "Life Begins", which has proved extremely popular to fair patrons in the past. Since this is a self-explanatory exhibit which indicates there is no need for any continuous staffing, the council has authorized the times for manning this exhibit be left to the discretion of the KMA Headquarters Staff.

We have reviewed and hoped to make use of a new booklet on health careers entitled, "Horizons Unlimited". Our interest in the health careers field

is a continuing effort of this council and we are observing a growing number of organizations, committees, commissions, etc., who appear to have an interest in this same area.

This past year your council has discussed the merits of the possible introduction of an organized speakers bureau as an activity of KMA. This council has served in this capacity in the past and numerous speakers have been made available to other organizations. A speaker's bureau kit is being secured and a more in-depth study of a speaker's bureau will be made and the results considered at a forthcoming meeting of the council.

The ten committees serving under this council are: Rural Health Committee, Diabetes Committee, Committee on Disaster Medical Care, School Health Committee, Highway Safety Committee, Public Health Committee, Advisory Committee to Woman's Auxiliary, Senior Day Committee, Committee on Medicine and Religion, and Orientation Committee. The following final reports of the committees are herewith submitted:

Diabetes Committee

Irving F. Kanner, M.D., Lexington, Chairman

Your Diabetes Committee met one time during the associational year, March 2, 1966, and concentrated its attention on planning and promotion of the sixteenth annual Diabetes Detection and Education Drive which will be held during the week of November 13-19. Representatives of the State Health Department attended our meeting and were very cooperative in planning the 1966 drive.

Members of the committee reviewed the results of the 1965 Diabetes Drive and found that 66,501 free tests were reported, 252 new diabetics were reported, and 985 positives. It was pointed out that this decline in the number of people reportedly tested during the 1965 Diabetes Detection and Education Drive was due to the method of reporting results of the 1965 campaign. In all probability, as many or more than the 100,000 reported in 1964 were tested this year.

We would like to take this opportunity to express appreciation to all local county medical society Diabetes Chairmen, all KMA members, allied groups and cooperating organizations, that enabled us to continue this outstanding public service program. Since the first program in 1951, more than 2,500 previously unknown diabetics in Kentucky have been found.

The guests from the State Health Department explained to committee members that plans have been formulated for a year-round blood-sugar testing diabetes program through the county health departments. It was suggested that this program could be used as follow-up for the urine testing program in cases where physicians thought it necessary. It was pointed out that although this program is originating in the State Health Department, it will have to be pushed and encouraged by medical societies in that the health department cannot give these follow-up tests without the approval of the individual's physician.

Your committee is looking forward to a most successful drive in 1966 and again encourages the participation of all Kentucky physicians in this program.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of the Diabetes Committee. "Mr. Speaker, I move the adoption of this section of the report." (Motion seconded; carried.)

Highway Safety Committee

John J. Robbins, M.D., Louisville, Chairman

At our meeting on May 24, we had as our guests, Richard Braisted and John Fitzgerald of the Cornell Automotive Crash Injury Research Program, Buffalo, New York; Lieutenant Judson Edwards and Mr. Donald Sullivan of the Kentucky Department of Public Safety, and Major E. J. Hyde of the Louisville Police Department.

Mr. Braisted and Mr. Fitzgerald presented a very conclusive report on the three-year Automobile Crash Injury Research Program in Kentucky which began in October, 1962 and was completed this past July. Sample areas for the investigation of vehicular accidents creating injuries were rotated every six months and your committee hopes to express its appreciation to all KMA members who cooperated in this program. KMA was a co-sponsor of this project with the Kentucky Hospital Association, Department of Public Safety, and the State Health Department. The 1965 House of Delegates gave approval for ACIR to continue its program for another year in Kentucky and it is anticipated the new project may begin this fall.

Two years ago this committee, working with the Department of Public Safety and the State Health Department was instrumental in developing a Driver Limitation Program in Kentucky. Again, we want to express appreciation to every physician who has cooperated in this program and completed the necessary medical examination forms on request.

Mr. Don Sullivan reported to us on the first two years of the Driver Limitation Program and stated that 1,153 cases have come before the Medical Review Board as of May, 1966. He also reported that Kentucky is the only sate that has a Driver Limitation Program.

Your committee also held a discussion on S.B. 1251 concerning federal legislation for automobile safety standards with the consensus that this would soon be law. The AMA is on record as supporting this legislation.

Continuing efforts are now being made to establish a joint Highway Safety Committee between KMA and the Kentucky Bar Association.

The committee received for information a report on the KMA Disaster Medical Care Committee's efforts to have signs showing location of hospitals with emergency facilities placed on limited access and interstate highway systems.

Your committee has continued its efforts in the encouragement of seat belts in cars and the awarding of automobile safety awards to any group which has seat belts in 100 percent of their member cars. This certificate is being brought up-to-date and it is anticipated that they will be awarded to the Louisville Police Department and the Department of Public Safety in the near future. Since the automobile safety award's presentation was initiated some two years ago, eight companies or organizations have received such certificates for 100 percent seat belt installations in their automobiles.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the committee report on Highway Safety. "Mr. Speaker, I move the adoption of this section of the report." (Motion was seconded and carried.)

Medicine and Religion Committee

Joseph H. Saunders, M.D., Lexington, Chairman

The Committee on Medicine and Religion met on May 4, 1966, with four of the nine members present, to discuss ways to stimulate interest and to develop a more effective state-wide program on this subject. This meeting was attended by Mr. Arne Larson, assistant director of the Department of Medicine and Religion of the American Medical Association.

Appointments of fifteen trustee district chairmen for medicine and religion have been made during the past year. These chairmen are being provided with the necessary resource materials and information from the AMA in order to be prepared to carry out their responsibilities in the future.

Mr. Larson explained that the purpose of the state committee is to promote the activities of medicine and religion in the state association and the county medical societies. The members of the state committee and the trustee district chairmen should assist the physicians in the county medical societies to develop a program on this subject. They should encourage them to consult with ministers in their areas, exchange ideas, and perpetuate a working relationship with the clergy in the care and treatment of a patient. The county medical societies should be stimulated individually or as groups to originate presentations and develop programs in their communities on medicine and religion. By having the physicians originating these activities, you may succeed in having many religions involved.

An orientation meeting for these newly appointed trustee district chairmen will be held in conjunction with the committee breakfast meeting scheduled for Wednesday, September 21, at 7:00 a.m., in Parlor A at the Kentucky Hotel, during the KMA Annual Meeting. Members of the staff of the AMA Department of Medicine and Religion will also be in attendance at this important organizational conference.

The Committee on Medicine and Religion would like to recommend to the Board of Trustees through the Council on Communications and Public Service that since these trustee district chairmen for medicine and religion have only just been appointed, that they be allowed to continue to serve in this capacity for the year 1966-67.

Since the chairman has served this committee for two years, it is requested that a successor be appointed to chair this committee for the coming year.

The committee will have an AMA exhibit at the KMA Annual Meeting. Members will be on hand at all times to acquaint KMA members with the purpose and intent of its program. Pamphlets and materials will be available for distribution on this subject.

Efforts in the coming year will be devoted toward the development of future programs on medicine and religion and the further stimulation of interest in this field of endeavor on the county medical society level.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of Medicine and Religion Committee. "Mr. Speaker, I move the adoption of this section of the report." (Motion seconded; carried.)

Orientation Committee

N. Lewis Bosworth, M.D., Lexington, Chairman

Your Orientation Committee has had an active year in conducting the second KMA Orientation Course on April 13 during the KMA Interim Meeting, planning the third course which will be held on Monday, September 19, just prior to the opening of the 1966 KMA Annual Meeting, and analyzing the results of the first course to make appropriate adjustments.

The House of Delegates, in session in September, 1964, reaffirmed the policy adopted in 1963 that all new KMA members would have two years after joining the Association to take an Orientation Course that would be offered at least four times during the first two years of membership. It is your committee's opinion that this program has been most successful and has aided our Association in another step forward. The compliments that have been extended to this committee should rightfully be passed on to the members of the House of Delegates, our officers, the county societies, speakers on the program and the new members themselves.

At our first program in September, 1965, we had 56 new members in attendance, which constituted 50 percent of those eligible. An additional 27 attended the program at Cumberland Falls in April. Our largest attendance to date is anticipated at the September 19, 1966, Orientation Course, as approximately 120 will be extended invitations to be in attendance.

Your committee would like to remind the KMA members who joined the Association on or after January 1965, or prior to our first program the following September, that if they have not taken one of the three courses offered to date, the fourth opportunity will be during the 1967 Interim Meeting. The Bylaws state the program must be attended in one of these four opportunities unless excused for reason by the Board of Trustees.

Your committee has met twice during this past associational year to plan forthcoming Orientation Programs on each occasion and make such changes as might be indicated following a review of the last course presented. To date, we have used the same speakers on the two programs completed and a special expression of appreciation goes to these individuals for the time they have expended in preparing for and appearing on these programs. Their contributions have added much to the success of this new KMA sponsored activity.

Recommendations, Reference Committee No. 4

"Mr. Speaker, I move the adoption of this section of the report," with a special commendation to the Orientation Committee for the outstanding job which they are doing. (Motion was seconded and carried.)

Public Health Committee

Ralph D. Lynn, M.D., Elkton, Chairman

The KMA Public Health Committee met on February 24, 1966, and concentrated the greater portion of its attention on planning of the Immunization Week Program.

Members of the committee approved the promotional material for the program, which was held from May 1-7 by proclamation of Governor Edward T. Breathitt. It was the consensus that Immunization Week continues to be a very effective stimulus in getting children immunized before one year of age.

Thomas S. Wallace, Jr., M.D., Director of the Louisville and Jefferson County Health Department, also a member of the committee, gave a comprehensive report of the conference he attended on Veneral Disease in Chicago, sponsored by the American Medical Association.

He reported that VD has been on the rise since 1956 and that four organizations—U.S. Public Health Service, American Social Health Association, American Veneral Disease Association, and American Medical Association—have endorsed a program as to what should be done in the way of VD control. Members of the committee recommended that the Board of Trustees encourage local county medical societies to actively participate in the introduction of VD instruction in the curriculum at junior and senior high schools in local counties. (The Board of Trustees acted on this recommendation at its August 3 meeting.) The committee also suggested the use of the Communicator and the secretary's newsletter to encourage local societies to stimulate community

action in VD programs.

Several items discussed by the committee were received for informational purposes. These included:

1. AMA Committee on Environmental and Public Health Report.
2. Resolution #3 introduced by the Illinois Medical Association delegation at the AMA Clinical Meeting pertaining to the effect upon population restlessness of overcrowded and unsanitary living conditions.
3. Results of the 1965 Diabetes Detection and Education Drive.
4. Report on the Metropolitan Life Insurance Company's project which is a nation-wide public education campaign focusing attention on prevention and care of medical emergencies in local communities.

The committee discussed in great detail benefits derived from Community Health Week, which is designed to direct public attention at the local level to the health progress and medical advances which have been made to protect and improve health. Members of the committee felt Community Health Week to be very worthwhile and agreed to maintain an active interest in the program with the thought of possibly enlarging it in the future along the lines of Immunization Week.

Dillard Turner, M.D., Director, Office of Local Health Services, State Department of Health, was a guest at our meeting and reported on many health programs currently being carried out by the Health Department. Among those mentioned included: diagnostic screening, maternal and pediatric clinics, retardation clinics, military rejectees program, hearing and speech disorders, health for migrant workers, health facilities, infant immunization, and school health programs of various types.

Your chairman wishes to thank all the members of the committee for their interest and participation in the many facets of concern which fall under the responsibility of your committee.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of the Public Health Committee. "Mr. Speaker, I move the adoption of this section of the report." (Motion seconded; carried.)

Rural Health Committee

Donald L. Graves, M.D., Frenchburg, Chairman

The Rural Health Committee met on December 2, 1965, with five of the nine members present.

The Annual Rural Health Conference held in Hopkinsville on October 21, 1965, was discussed. The subject of the Conference was "A Profile of Health Services, Resources, and Unmet Needs in Western Kentucky". The committee reviewed the Annual Conference and the meeting of the Kentucky Rural Health Council, noting the small attendance of physicians. The question was raised as to whether the Annual Conference was accomplishing the original goals, since most of the original objectives are already being done by other groups.

The suggestion was made that it might be better to focus support in local areas in an effort to provide physicians in the needed rural areas. In this connection, the Rural Kentucky Medical Scholarship Fund, which provides $2,000 to physicians who will establish a practice in the most critical counties, and the University of Kentucky Family Practice Training Program were mentioned.

Consideration was also given to contacting the two medical schools and requesting that time be permitted to counsel with the students each year of their training in an effort to make them more aware of the opportunities available in general practice in the rural areas.

It was pointed out that the Annual Rural Health Conference requires approximately a month of staff time in the completion of all arrangements. This committee would like the record to show that should the Annual Rural Health Conference continue, it is suggested that less time be required of the KMA staff in promoting and working it.

Joseph Hamburg, M.D., Lexington, a member of the Rural Health Committee, and a member of the staff at the University of Kentucky College of Medicine, attended the AMA Council on Rural Health at Colorado Springs on March 18-19, 1966.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of the Public Health Committee. "Mr. Speaker, I move the adoption of this section of the report." (The motion was seconded and carried.)

School Health Committee

O. B. Murphy, M.D., Lexington, Chairman

The activities of the School Health Committee during its two meetings on February 23 and May 11, centered around obtaining a better physical education program in the state's school system.

The present physical education program in the school system is at a bare minimum and not adequate. On several occasions your chairman and other members of the committee met with officials of the Department of Education to seek improvements in the physical education program, but were told there is no budget at the present for salaries and additional personnel to do this job.

The committee intends to continue its work by meeting with the following groups: KEA, PTA, Kentucky Association of Physical Education and Recreation, and Department of Education to let them know of the medical profession's interest in this area.

The committee discussed holding one or two Athletic Injury Prevention Conferences a year to keep physicians informed. It was pointed out that the committee had sponsored these meetings in the past, but attendance was not satisfactory.

Your committee continued its liaison with county medical society School Health Chairmen and planned another meeting of the chairmen during the KMA Annual Meeting. Members of the committee discussed the role of the physician in regard to the teaching of health in the schools. It was agreed that the physician should act only in an advisory capacity, but also felt that school superintendents should know there is a county School Health Chairman who could be called on for assistance.

Your committee continues its interest of making available health education material to students on request and to health educators in our school system. Members of this committee helped staff an exhibit at the 1966 Annual Meeting of the Kentucky Education Association in which we discussed health education materials that were available to the teachers and sent supplies of these materials to those who requested them.

The committee failed to have a quorum at either of its two meetings during the year and members felt that in the future, only physicians vitally interested in school health should be appointed to serve on the committee.

Recommendations, Reference Committee No. 4

The report of the School Health Committee was reviewed. "Mr. Speaker, I move the adoption of this section of the report." (Motion was seconded and carried.)

Senior Day Committee

Fred Rainey, M.D., Elizabethtown, Chairman

Your KMA Senior Day Committee met on November 12 and planned Senior Day programs for the University of Louisville and the University of Kentucky graduating medical students. We wish to express deep appreciation to those physicians who took a day from their busy practices to present these two highly successful programs. The University of Louisville Senior Day Program was presented on March 21, 1966, with the opening session taking place in the Rankin Amphitheatre, Louisville General Hospital. The afternoon session was held at the Executive Inn.

The students received the program with enthusiasm and afterwards gave very favorable reports to members of the Senior Day Committee. Guest speaker for the evening was Mr. C. V. Edwardson, Louisville, a first vice-president of the Lincoln Income Life Insurance Company.

A similar program was presented to the seniors at the University of Kentucky on April 12, 1966. The response was equally as favorable and several suggestions were offered by students of both medical schools for the committee members to consider in planning next year's sessions. Donovan F. Ward, M.D., past President of AMA, was featured speaker at the University of Kentucky evening program. Copies of Doctor Ward's talk are available at the KMA Headquarters Office.

Everett H. Baker, M.D., Louisville, President of KMA, delivered an outstanding talk at the opening session of both programs. His speech, "The Challenge of the 1966 Medical Graduate", received many favorable comments from the students.

The chairman wishes to express his appreciation to members of the committee for their interest and cooperation in planning these very worthwhile senior day programs. The success of these programs is largely due to the participation of those KMA members who spoke to the senior students, and we are indeed grateful for their participation.

Recommendations, Reference Committee No. 4

The report of the Senior Day Committee was reviewed. "Mr. Speaker, I move the adoption of this section of the report." (Motion seconded; carried.)

Advisory Committee to the Woman's Auxiliary

Coleman C. Johnston, M.D., Lexington, Chairman

As chairman of Kentucky Medical Association's Advisory Committee to the Woman's Auxiliary, I would like to observe that we have had a pleasant year with no complications or problems requiring a meeting of the committee.

Upon several occasions, I had the distinct pleasure of conferring with our President, Mrs. Robert J. Salisbury, and discussing some of the ideas which she had in mind. We discussed the possibility of a visit of our ladies auxiliary group to Frankfort while the legislature was in session. Plans were made to meet H. D. Gardner, M.D., and many of the representatives and senators from the various districts. It was felt this would be a valuable meeting, and I am sure that it was quite successful. Upon other occasions, committees of the McDowell House Shrine were reviewed and apparently our ladies are contributing considerably to this worthwhile cause.

Again the development of the Frontier Nursing program was discussed and the auxiliary members have given this matter enthusiastic support.

Please accept this report of the Chairman of the Advisory Committee of the Ladies Auxiliary and many thanks for the privilege of serving.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of the Advisory Committee to Woman's Auxiliary. "Mr. Speaker, I move the adoption of this section of the report." (The motion was seconded and carried.)

Disaster Medical Care Committee

William T. Rumage, Jr., M.D., Louisville, Chairman

The Disaster Medical Care Committee of the Kentucky Medical Association met on three occasions during the past year. The chairman is grateful to those members of the committee who were faithful in their attendance at the meetings and who accepted and fulfilled their assignments. Others on the committee made no contribution whatsoever. This chairman would suggest that when the letter of announcement is sent to new committee members that they be asked if they really wish to participate in the committee and if they don't, then they should be allowed to resign at once and an effort made to appoint others in their place.

In addition to the appointed members of the committee, our meetings were attended by a large number of people, both laymen and professionals, who represented other private and governmental agencies in Kentucky concerned with Disaster Medical Care. This list of guests included representatives of the Health Department, the armed services, the University of Louisville, the University of Kentucky, the American Red Cross, the Kentucky Pharmaceutical Association, the Kentucky Funeral Directors' Association, the Kentucky Hospital Association, the Kentucky Dental Association, and the Kentucky Nurses' Association.

The following items were considered during the past year. They are not listed in any particular order.

1. Your committee and the Kentucky Hospital Association have continued their combined efforts to establish a program of identification of hospitals with emergency facilities along the interstate road system. Your committee representatives attended public hearings held in Frankfort sponsored by the United States Bureau of Public Roads. There is some nationwide support for this project and your committee hopes that it will prove to be worthwhile.
2. Your committee additionally has worked with the Kentucky Hospital Association on a survey of transportation of the sick and injured in Kentucky. The survey was designed to determine how the sick and injured are transported in Kentucky and the training qualifications of those people in attendance. It would appear that those who are transporting the sick and injured are well-meaning but lack training in advanced first aid.
3. Your committee has invited representation from the Kentucky Funeral Directors' Association because traditionally, in the rural areas in particular, the funeral directors transport the sick and injured. Additionally, your committee was represented at a Kentucky Funeral Directors' Association meeting. It is the hope of your committee that a program can be developed to improve the first aid training of those members of the Kentucky Funeral Directors' Association who are actively engaged in transportation of the sick and the injured.
4. Your committee is working with the Kentucky Hospital Association in the development and presentation of a questionnaire to hospitals across Kentucky about some of their emergency facilities, particularly their emergency power stations, their communications with each other

and governmental agencies, and also the availability of whole blood for transfusions. The results of this survey will be reported at a future date.

5. Your committee has been working with Kentucky governmental agencies on the problem of hospital communications in an effort to determine how many hospitals do have emergency communication facilities and whether these can be related to each other.
6. Your committee was represented at a Professional Training Seminar held in Frankfort in July of 1966. This seminar was designed to determine the part that should be played by ancillary services at times of emergency. There is considerable discussion about the relationship of these ancillary services to the medical profession. It would seem logical that the medical profession rather than the governmental agencies should be responsible for the development of such programs.
7. Your committee has been working with the Kentucky Dental Association in the assignment of dentists at the time of disaster. It is hoped that these dentists will be accepted into the disaster medical care activities of their counties or areas.
8. Your committee has been very much interested in the establishment of a roster of professional people and services available at the time of disaster not only in medicine, but in the ancillary services and subsequently recommends an annual registration of physicians in Kentucky. The details of such registration should be investigated with the Kentucky Health Department. It is conceivable that this registration can be completed with little or no expense to the individual doctors in Kentucky.
9. Your committee has been examining the Mutual Aid Pacts which exist between Kentucky and the adjoining states. These are agreements by which Kentucky will come to the aid of any or all of the adjoining states at the time of a disaster occurring in those areas and, of course, the converse is true. It is conceivable that some form of Good Samaritan Legislation will have to be passed to supplement the effectiveness of these mutual aid pacts. This is a matter that will probably be investigated by the American Medical Association and its legal advisors and no further action at this time seems indicated.
10. Representatives of your committee have worked with the Kentucky Health Department in the development of the Governor's Emergency Health Resources Plan. As yet the plan has not been published, but we have been assured that it will be available in the near future.
11. At the present time, there are 45 packaged disaster hospitals in the Commonwealth of Kentucky. Kentucky is scheduled to receive five more such hospitals in the future. 20 of these hospitals have supplies and equipment to keep the hospital in operation for 30 days on an emergency basis. Your committee has been concerned about the staff assignments in these hospitals and we are not certain at this time that they are adequately staffed. However, the State Department of Health has assumed the responsibility for staff assignments in these hospitals and as they are made, these will be reported.
12. Over 43,000 individuals in Kentucky have been trained in medical self-help.
13. Your committee continues to be interested with the American Red Cross in improving first aid facilities in industry and schools.
14. Your committee continues to maintain an interest and receive reports from the Medical Education for National Defense Departments of both the University of Louisville and the University of Kentucky. Members of the committee have participated in these programs.
15. Your committee continues to be interested in widespread immunization as part of disaster medicine with particular concern about immunization against tetanus. Your committee speculates about the number of doctors who have allowed their tetanus immunization to expire.
16. Your committee continues to gather information about the feasibility of a fallout shelter in the Headquarters Building of the Kentucky Medical Association.
17. Representatives of your committee participated in "Operation Mercy" in Memphis, Tennessee. This was a community disaster exercise and such exercises should be encouraged and sponsored by state and local medical organizations.
18. Your committee was represented at the Kentucky Rural Health Conference. A presentation was made on Community Disaster Programs.

The chairman and committee wish to take this opportunity to express their gratitude to the staff of the Association for their hard work during the past year in the assignments of this committee.

COUNCIL ACTION: It is recommended that the report of the Disaster Medical Care Committee be accepted as presented with the exception that no action was taken on Item No. 8 because of lack of background information and it is hoped that more detailed facts can be presented to the Board of Trustees and House of Delegates.

COUNCIL ON COMMUNICATIONS AND PUBLIC SERVICE
N. Lewis Bosworth, M.D., Lexington, Chairman
Donald L. Graves, M.D., Frenchburg
Irving F. Kanner, M.D., Lexington
Ralph D. Lynn, M.D., Elkton
O. B. Murphy, M.D., Lexington
Fred C. Rainey, M.D., Elizabethtown
John J. Robbins, M.D., Louisville

This report was reviewed by the Board of Trustees August 4, 1966.

BOARD ACTION: Approved, with the observation in approving the report of the Disaster Medical Care Committee, the Board has already endorsed the concept of annual registration.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of the Disaster Medical Care Committee. "Mr. Speaker, I move the adoption of this section of the report." (The motion was seconded and carried.)

Report of the Council on Medical Services

Page 14, first full paragraph thru page 15

Physicians Placement and Membership Committee

In addition to the requests coming into our office, we are constantly working to fulfill the needs in the more critical counties of Kentucky.

In the last three years, this committee has recommended twice that the KMA approve the concept of annual registration. An excerpt from our previous reports to you states: "After reviewing the method by which the staff gets its membership information, we find the source to be inadequate. Once a physician gets a license through the Division of Medical Licensure of the State Department of Health in Frankfort to practice in Kentucky, he has no legal obligation to inform the Division, or the Medical Association where he will practice. He can move from county to county, leave the state and return as many times

as he wishes and do this without either reporting to the Division of Medical Licensure or to the Headquarters Office. With this method of keeping up with our doctors, we cannot expect our membership department to have accurate records on all practicing physicians in our state.

Our committee decided that the best solution for this problem would be to have annual registration of physicians and that this be done by the Licensure Division of the State Board of Health. After checking with Russell E. Teague, M.D., Commissioner of Health, we find that his department can require annual registration by regulation instead of by legislation, which will have the effect of law, and this can be done without an annual registration fee.

Thirty-five states require physicians to register annually, and another ten require registration biennially."

It is our understanding that this matter is being recommended this year by the KMA Committee on Disaster Medical Care, following careful consideration and detailed discussions. This committee would like to take this opportunity to strongly urge the KMA House of Delegates to concur in the recommendation on annual registration being made by the Committee on Disaster Medical Care.

COUNCIL ACTION: It was recommended that the report of the Physicians' Placement and Membership Information Committee be accepted as presented, and the council strongly urges that the House of Delegates approve the recommendation of this committee on annual registration.

Recommendations, Reference Committee No. 4

The Reference Committee considered at length the merits of annual registration and recommends the adoption of annual registration to be administered by the State Department of Health with no registration fee being charged. "Mr. Speaker, I move the adoption of this section of the report." (Motion seconded; carried.)

Report of the Council on Allied Professions and Related Groups

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the by-laws, which reads in part:

". . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Allied Professions and Related Groups is presented in the following order:

1. *Actions and recommendations by the council which it undertook on its own initiative.*
2. *Resorts of the committees of this council with the council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the over-all contents at the conclusion of the report.*

The Council on Allied Professions and Related Groups met once this associational year on June 23. Members of the council discussed the various committees of this council and their activities and reviewed the duties of the council itself.

We received an informational report that the KMA-KNA Joint Advisory Committee last year made specific recommendations to the governing body of each organization. These recommendations have not been finalized to date and the Joint Advisory Committee plans an early fall meeting to make revisions as necessary.

In addition to taking appropriate action on the final reports of the committees serving under this council, specific action was also taken on a few separate recommendations that were made by the committees which will receive final action by the Board of Trustees during the August meeting.

In addition to the final report submitted by the Tuberculosis Committee to the council, Richard Mardis, M.D., appeared in person to submit an addendum, acting for the committee chairman, Joseph Humpert, M.D., who was out of the state. He submitted reference material to support the request of the committee that this council recommend through channels that the detection and treatment of tuberculosis in the commonwealth be unified under one authority, namely the Kentucky Tuberculosis Hospital Commission. After due consideration of the following:

1. Since universal school testing, subject to the approval of the local county medical society, was advised by the Kentucky Medical Association in 1964 in grades one through twelve has not been instituted;

2. Since 85 percent of the cases detected are graded as moderate or far advanced;

3. Since the number of new cases reported annually has remained static since 1959 suggesting no improvement in treatment during this period;

4. Since the TB Committee of the KMA agrees unanimously that emphasis should be placed on tuberculin testing of the school population, grades one through twelve, followed by chest survey of all positive reactors and their immediate contacts; and

5. Since according to the statement of Stuart Lauder, M.D., Director of TB Control of the Health Department, a current register of TB cases was nonexistent in 49 counties (41 percent), the council has voted to endorse the recommendation of the TB Committee and recommends endorsement through channels that the detection and treatment of tuberculosis in the commonwealth be unified under one authority, namely the Kentucky Tuberculosis Hospital Commission.

(The five preceding numbered items and the paragraph immediately preceding them were referred to Reference Committee No. 5.)

The committees serving under the council are: Dental-Nurse-Pharmacy Committee, Physical Medicine and Rehabilitation Committee, Maternal Mortality Study Committee, Perinatal Mortality and Morbidity Study Committee, Tuberculosis Committee, Blood Banks Committee, Industrial Medicine Committee, and Cancer Coordinating Committee.

The following are the final reports of these committees.

Blood Banks Committee

Ellis A. Fuller, M.D., Louisville, Chairman

The Blood Bank Committee met once during the year, reviewed its 1965 report to the House of Delegates and its relation to the Council on Allied Professional and Related Groups.

Activities during the year centered mainly on two items:

1. Review of New Jersey, Michigan, and California laws pertaining to many aspects of blood banking, and
2. Plans for a special edition of the KMA Journal on blood banking.

Members of the committee discussed the pros and cons of each law in an attempt to ascertain whether an effort should be made to draw up legislation in

this field for Kentucky. It was felt that blood banking is a practice of medicine and physicians have the responsibility of maintaining its high standards; and if individual physicians do not, then it is up to the local county medical society to step in and stress the importance of this responsibility.

It was agreed that the committee not pursue medical legislation pertaining to rigid controls of blood banking, but members felt that KMA should encourage local medical societies in the maintenance of proper standards in the blood bank area. It was felt the committee should function as a general source of information for the county societies and provide assistance wherever and whenever needed.

Considerable time and discussion during the year occupied members of the committee in regard to the special edition of the Journal which will be published in October 1966. Members of the committee outlined the following possible topics for inclusion in the Journal:

1. Use of Whole Blood and Packed Cells
2. Medical Hazards of Transfusions
3. Medical-Legal Aspects of Transfusions
4. Proper Laboratory Control in Blood Banking
5. Plasma Fraction—Component Therapy

Also to be included is an editorial on physicians encouraging patients to replace blood they use.

Resolution 26, entitled "Payment for Blood and Blood Plasma from the Society-Sponsored Insurance Programs," introduced by the Illinois delegation at the AMA House of Delegates at the 1965 AMA Annual Meeting, was brought to our attention and this committee endorsed the action of the House of Delegates on this resolution. The committee also discussed the AMA Blood Bank Committee report presented at the 1965 Clinical Meeting.

During the year this committee was asked by the Kentucky Department of Insurance for its position regarding "health insurance policy providing money indemnities for the cost of whole blood or plasma administered to covered patients." Your chairman stated this committee's position as follows: "That the payment of money indemnities under health insurance contracts without a concomitent requirement for the beneficiary of the policy to obtain replacement blood runs counter to the desire of the medical profession and volunteer blood banks to obtain replacement or blood supplies along the lines which have been established since World War II."

Your chairman wishes to express his appreciation to the members of this committee for their support and diligent efforts throughout the year.

Recommendations, Reference Committee No. 4

The committee reviewed the report of the Blood Bank Committee. "Mr. Speaker, I move the adoption of this section of the report." (The motion was seconded and carried.)

Cancer Coordinating Committee

Condict Moore, M.D., Louisville, Chairman

The Cancer Coordinating Committee met three times during the last year, each time mainly concerned with helping the Kentucky State Department of Health plan a working protocol for a state-wide cervical cancer screening program. The best summary we can give of the year's work is to enclose a copy of the working plans for this cancer screening program as they have been developed, with advice and thought from all members of the committee. C. E. Hernandez, M.D., M.P.H., Director of the Division of Epidemiology, will be in charge of the over-all program and has done a good job of incorporating the committee's suggestions into this protocol. A copy of the protocol is enclosed.

The committee also wishes to submit the working plans to the House of Delegates of the Kentucky Medical Association for consideration of approval by that body.

The committee also voted to recommend to the House of Delegates that two additional members be appointed to the committee, one a pathologist and one a radiotherapist, so that these vitally involved specialists might have ready and adequate representation when clinical cancer problems arise.

Working Plans for Cervical Cancer Screening Program

With the advice of the Cancer Coordinating Committee of the Kentucky Medical Association, the Kentucky State Department of Health is establishing a statewide cervical cancer cytology screening program.

The reasons for and the background of this program are as follows:

1. The Papanicolaou smear test has been demonstrated as effective in finding pre-cancer and occult early cancer.
2. Local community screening programs over the country have been successful in reducing the incidence of invasive cervical cancer. Jefferson County, Kentucky, is one such community.
3. Money earmarked for this program, at the request of Russell E. Teague, M.D., State Health Commissioner, was appropriated by the Kentucky State Legislature in 1966.

Preliminary Preparatory Contacts

Letters from the Cancer Program, Kentucky State Department of Health, will be sent simultaneously to each county health department and to each county medical society in the state to announce that the department is prepared to assist communities in establishing cervical cancer screening programs. The letter will state that the general outline of the program has been endorsed by the Cancer Coordinating Committee of the Kentucky Medical Association, and the endorsement of the Kentucky Medical Association will be sought at its Annual Meeting in September. The county health departments and the county medical societies will be advised to direct questions concerning policy and procedure for the program to the Cancer Program, Office of Chronic Disease, Division of Epidemiology, Kentucky State Department of Health, and questions concerning Kentucky Medical Association policy to the Cancer Coordinating Committee, Kentucky Medical Association.

The letters will suggest that this service be discussed by the medical society, the local health officer, and a representative of the Cancer Program at an early meeting of the society. The letter to the health officer will request that he obtain approval for the program from his board of health prior to the meeting with the medical society. No activity will be authorized by the Cancer Program until the approval of both the county board of health and the county medical society has been received.

At the medical society's meeting, health department representatives will briefly outline the components of the program and answer questions which the physician may ask about it. If the medical society requests that the county health department initiate a program, the medical society should appoint several of its members to form the nucleus of a planning committee. Others who should be included in the planning committee are the local health officer, representatives of appropriate volunteer women's organizations, the chairman of the local chapter of the American Cancer Society, and hospital administrators (if the clinics are to be held in a hospital). Personnel from the Cancer Program of the Kentucky State Department of Health will be available as consultants. Below are guidelines and suggestions for the detailed operation of the program. These have worked in similar programs in other communities, but local groups must feel free to design their own programs.

Objectives

The objectives are (1) to demonstrate (a) the value of the test for individual health and for prolonged life, (b) the simplicity of the test, (c) the obvious advantages of including it as a routine part of every complete examination of a female patient, and (d) the need for careful and complete follow-up, and (2) to discover unsuspected cancers and carcinomas-in-situ.

Eligibility

The Kentucky State Department of Health will consider any female resident of Kentucky over the age of twenty eligible for this service. Those less than twenty years of age will be accepted only on referral from a physician. This does not preclude the establishment of further eligibility criteria by local planning groups.

Clinic Location

When feasible the clinics should be conducted in the county health department. If this is not possible, a hospital, physician's office, or other suitable place may be used.

Duration and Frequency

A continuous clinic with an established periodic schedule is preferable to a mass screening effort over a limited amount of time. A periodic schedule with pre-registration affords an opportunity to enrich the educational aspects of the program by allowing the nurse or physicians time to discuss the test with the women individually.

At the time of registration, each screenee will be given a pamphlet which will provide such information as the purpose of the test, the simplicity of the technique, and the importance of periodic retesting.

Supplies

All necessary supplies will be furnished by the Kentucky State Department of Health. Usually these will consist of specula, gloves, scrapers, swabs, slides, mailing containers, fixing material, and all necessary forms. Requests for additional items will be considered if their use adds to the medical value of the examination.

Staff

It is strongly recommended that adequately trained public health nurses, under direct medical supervision whenever possible, be given primary responsibility for obtaining smears. They have been highly successful in this work in several communities throughout the state. It should be emphasized that this is only a simple screening procedure. If local physicians wish to volunteer, they may staff screening clinics held in the county health department, the local hospital, their own private offices, or another suitable place. Health officers may staff clinics where this is possible.

The organization and use of volunteer workers is essential in every clinic. American Cancer Society volunteers, junior women's clubs, homemakers, women's auxiliaries, etc., should be contacted early in planning and asked to assist in registering, help place participants on the examining tables, fix slides, etc.

Training

The Kentucky State Department of Health will send public health nurses to appropriate physicians for practical training in the smear-taking technique. To a limited extent this is now under way. An effort will be made to develop a suggested standard procedure throughout the state for training nurses in this technique.

Pathology Services

A list of laboratories where pathology services are available will be furnished to each planning committee. It will be the committee's responsibility to make arrangements with a pathologist of its choice to have the slides read. The Kentucky State Department of Health will pay for this service at a pre-determined rate, which will be worked out with the Society of Pathologists and will be uniform over the state.

Reporting and Billing

Reports of microscopic cervical cell studies should be sent by the pathologist directly to the county health department which submitted the specimens, along with the bills submitted to the county health department. The county, after certifying the bills, will forward them to the Kentucky State Department of Health for payment.

Follow-Up

Upon receipt of the pathologist's report, the county health department will send a post card to each woman for whom there is no positive finding. The card will tell her that the examination revealed no evidence of cervical cancer. The specific nature of the screening test will be described, and she will be told that repeated examinations should be carried out periodically. Her private physician, if any, will also be notified of the negative finding.

If the cytology report indicates the need for further study, the county health department will inform the private physician and make available the follow-up services of a public health nurse. However, if the physician wishes to assume responsibility for contacting the patient, the nurse should check with the physician after a reasonable length of time to see if there has been a response from the patient. If there has been no response, the nurse should again offer her services for follow-up. The follow-up procedures for women whose reports are positive and who are under the care of no physician at that time will be handled according to plans of the county planning committee.

If a biopsy is necessary, the Kentucky State Department of Health will pay for the cost of the tissue examination in an amount which will also be predetermined and uniform. The department, however, cannot make payment of the physician's fee, hospital charge, or any other service fee involved in obtaining the specimen to be biopsied. The Cancer Program will not be able to provide funds for treatment. If hospitalization, surgery, radiation, or other treatment is indicated, the county health department should work with other agencies, such as local chapters of the Kentucky Division, American Cancer Society, Medical Care, Vocational Rehabilitation, and university hospitals to find groups or individuals to assist those unable to pay.

Education

Professional: The Cancer Program will work closely with the Kentucky Medical Association and others interested in professional education. Programs consisting of lectures, seminars, and demonstrations can be arranged to increase the utilization of Papanicolaou testing in medical practice.

Lay: A public information and educational program will be conducted in each county to help to accomplish the educational objective which we seek. Group discussion, participation by volunteers, newspaper and radio publicity, and selected films and other educational methods and materials will be used. Whenever possible, a practicing local physician should be present at community meetings to answer questions. The presence of a physician is extremely desirable.

COUNCIL ACTION: The council accepted the report of the Cancer Coordinating Committee for information but took no official action.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of the Cancer Coordinating Committee and recommends that the eligibility be altered to state "The Kentucky State Department of Health will consider any medically indigent female resident of Kentucky over the age of 20 eligible for this service on referral by a physician." It should be noted that a representative of the State Department of Health, C. E. Hernandez, M.D., reported to this committee that this was the original intent of the State Department of Health and that apparently a typographical error prevented this understanding. The committee also points out that under duration and frequency of the established clinics that the periodic schedule is merely a suggestion. "Mr. Speaker, I move the adoption of this section of the report." (Motion seconded; carried.)

Dental-Nurse-Pharmacy Committee

Melvin J. Weber, M.D., Ludlow, Chairman

The Dental-Nurse-Pharmacy Committee met once during the year on April 12 with representatives of the Kentucky Pharmaceutical Association. This meeting is in line with our desire to cooperate with allied groups in the interest of better relations and better service to the public.

The agenda for the meeting was assembled by representatives of both groups and each item received considerable discussion, which resulted in greater understanding of the problem existing between the pharmacists and the M.D.s.

As a result of this meeting, the KMA Committee on Dental-Nurse-Pharmacy makes the following recommendations to the House of Delegates through the Council on Allied Professions and Related Groups. (It is understood the pharmacists are making the same recommendations to their governing body.)

1. That the Pharmaceutical Association be allowed to send a directive to individual physicians' offices recommending that the nurses not authorize refills of prescriptions on their own initiative but in all cases consult with the physician and preferably have the physician talk with the pharmacist.
2. That in view of the new drug abuse law the practice of physicians leaving prescription pads where they are available to patients should be discouraged and precautions taken.

The committee members discussed ways in which the committee could be more effective in working with the allied groups—dentists, nurses, and pharmacists—and it was agreed that two members of the committee be assigned to work with one specific group. These two physicians will keep in touch with their group, find out mutual problems, and the KMA Dental-Nurse-Pharmacy Committee will meet as a whole once or twice a year to report on the various groups' activities to formulate recommendations, and prepare a report. This committee stands ready to meet with anyone of these allied groups to discuss specific problems and it is our desire that good communications be maintained.

The committee received a report on the new pharmacy law passed by the 1966 session of the Kentucky Legislature, the new drug abuse control law passed by the federal government, and the Nurses Practice Act passed by the 1966 state legislature.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of the Dental-Nurse-Pharmacy Committee. "Mr. Speaker, I move the adoption of this section of the report." (The motion was seconded and carried.)

Industrial Medicine Committee

Walter L. O'Nan, M.D., Henderson, Chairman

The Industrial Medicine Committee met twice during the associational year — on April 20 and January 26, 1966. The committee reviewed its duties, its final report to the 1965 House of Delegates, and discussed various aspects of occupational health where attention from this committee is needed.

It was felt that the 1965 meeting between members of this committee and representatives of insurance companies to be very worthwhile and plans were made to hold another in 1967. Reports were made on the 25th Congress on Occupational Health, 1965 Governor's Occupational Health Conference, and the World Medical Association meeting held in London, England.

Members of the committee concerned themselves with many items of interest during the associational year and felt several required attention from the KMA Board of Trustees and House of Delegates.

1. Your committee feels that a list of Kentucky physicians interested in industrial medicine is needed and recommends approval be given to the committee to send out a letter to KMA members to determine who is interested in industrial medicine and from the returns, a list be compiled for reference.

2. The AMA Council has changed its name to Council on Occupational Health which the committee felt is more inclusive and up-to-date. We recommend that the name of the KMA Industrial Medicine Committee be changed to Committee on Occupational Health. (This paragraph was referred to Reference Committee No. 6.)

3. Your committee recommends that KMA continue to be a sponsor of the Governor's Occupational Health Conference and further recommends that a page in the KMA Journal be used for promotion of the conference.

4. Your committee recommends that the KMA Board of Trustees explore with the University of Louisville and University of Kentucky the possibility of setting up a training course for industrial audiometric technicians. It was pointed out in one meeting that a committee including representation of the American Industrial Medicine Association, American Hygienic Association, American Hearing and Speech Association, and American Association of Industrial Nurses have recently drafted a proposed training course for industrial audio-metric technicians.

5. Members of the committee discussed the possibility and need of an employee health service unit for employees of the state of Kentucky. The committee recommends that action be initiated for the establishment of an employee health service unit for employees of the state, that it be headed by a licensed physician administratively responsible to the Commissioner of Health, both for pre-employment examinations and continuing treatment of industrial injuries and illnesses.

The members also discussed the dual interest of this committee and that of the KMA Physical Medicine and Rehabilitation Committee regarding compensation laws and rehabilitation in the state. It was suggested that a member of the Industrial Medicine Committee meet with the Physical Medicine and Rehabilitation Committee and take part in the discussion of two particular items: (a) to probe the possibility of recommending to the KMA Legislative Council the advisability of changing some of the compensation and rehabilitation laws in the state or the formation of a committee to review the present laws, and (b) to review the Kentucky statutes pertaining to noise induced hearing loss.

We wish to bring to your attention that this committee has reference to a number of people working in industry doing audio-metric and visual testing without proper training or supervision. It is the

opinion of the committee that KMA should be made aware of what is going on in this area and further recommend that the following become a statement of KMA policy: "The administration of visual assessment and audio-metric testing constitute the practice of medicine and should, therefore, be under the written or verbal instruction of a physician."

Your chairman wishes to thank those members for their efforts in making this such a successful year and for their service on this KMA committee.

Recommendations, Reference Committee No. 4

The Reference Committee reviewed the report of the Industrial Medicine Committee and recommends its adoption with the exception of paragraph five on page 14 of the report. In reference to paragraph two of the report on page 15, the statement is approved with the observation, however, that visual assessment may include optometric refraction which is by law not confined to the practice of medicine.

Mr. Speaker, I move the adoption of this portion of the report. (Motion seconded; carried.)

Maternal Mortality Study Committee

John H. Siehl, M.D., Covington, Chairman

This is a report of maternal deaths that occurred in Kentucky for the years 1960-61-62-63. The following tables contain information obtained by the State Office of Biostatistics and by the Maternal Mortality Committee.

Two sets of tables are included. The numbered tables (1, 2, 3, etc.) contain the statistical analyses of deaths recorded by the Office of Biostatistics. These figures are obtained in accordance with the International Classification of deaths and are therefore the figures on maternal mortality which are comparable with the statistics from other states and/or countries, because of the standardized procedure of classification used.

The numbered and lettered tables (1a, 2a, 3a, etc.) contain the statistical analyses of the deaths reported by the Office of Biostatistics plus the study of additional deaths found by the Maternal Mortality Committee. This is so because in an effort to determine more correctly the actual number of deaths occurring in Kentucky, the Maternal Mortality Committee through the Maternal and Child Health Division of the State Department of Health began in 1960 to review all death certificates of females between 15-44 years of age. Many unrecorded maternal deaths were found in this way. These figures give us a more realistic information of maternal deaths in the state of Kentucky, but cannot be used for comparative purposes. Nevertheless, to emphasize the importance of this new method of review of death certificates, these numbered and lettered tables with the corrected (unofficial) figures are also included.

TABLE 1—MATERNAL DEATHS BY OCCURRENCE AND BY COLOR WITH RATES. KENTUCKY, 1963-1960

	Total		White		Non-White	
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate
1963	23	3.3	19	3.0	4	6.6
1962	29	4.1	22	3.4	7	11.2
1961	40	5.5	28	4.2	12	18.7
1960	29	3.9	27	4.0	2	3.1

TABLE 1a—MATERNAL DEATHS, BY OCCURRENCE BY COLOR, WITH RATES. KENTUCKY. 1963-1960

	Total		White		Non-White	
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate
1963	31	4.5	26	4.1	5	8.2
1962	42	5.9	30	4.6	12	19.2
1961	50	6.8	35	5.3	15	23.4
1960	41	5.6	36	5.4	5	7.8

TABLE 2—MATERNAL DEATHS BY OCCURRENCE, INDICATING THOSE DELIVERED AND THOSE NOT DELIVERED, WITH PLACE OF DELIVERY FOR THOSE DELIVERED, WITH RATES, AND PLACE OF DEATH FOR THOSE NOT DELIVERED, KENTUCKY, 1963-1960

			Delivered					No Delivery		
	Total		Hospital		Other		Not Stated	Hosp.	Other	Not Stated
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Deaths	Deaths	Deaths
1963	23	3.3	17	2.6	4	12.4	—	1	1	—
1962	29	4.1	22	3.3	4	10.5	—	2	1	—
1961	40	5.5	29	4.2	8	18.9	—	2	1	—
1960	29	3.9	20	2.9	7	15.1	—	2	—	—

TABLE 2a—MATERNAL DEATHS BY OCCURRENCE, INDICATING THOSE DELIVERED AND THOSE NOT DELIVERED, WITH PLACE OF DELIVERY FOR THOSE DELIVERED, WITH RATES, AND PLACE OF DEATH FOR THOSE NOT DELIVERED, KENTUCKY, 1963-1960

			Delivered					No Delivery		
	Total		Hospital		Other		Not Stated	Hosp.	Other	Not Stated
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Deaths	Deaths	Deaths
1963	31	4.5	22	3.3	4	12.4	—	4	1	—
1962	42	5.9	35	5.2	4	10.5	—	2	1	—
1961	50	6.8	37	5.4	8	18.9	—	3	1	1
1960	41	5.6	30	4.3	7	15.1	1	3	—	—

TABLE 3—MATERNAL DEATHS BY OCCURRENCE, BY ATTENDANT AT DEATH WITH RATES, KENTUCKY, 1963-1960

Year	Total		Physician		Midwife		Other		Not Stated
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths
1963	23	3.3	20	2.9	—	—	3	200.0	—
1962	29	4.1	25	3.6	1	4.7	3	198.7	—
1961	40	5.5	33	4.7	3	13.4	4	272.1	
1960	29	3.9	24	3.4	2	8.6	3	173.4	

TABLE 3a—MATERNAL DEATHS BY OCCURRENCE, BY ATTENDANT AT DEATH WITH RATES, KENTUCKY, 1963-1960

Year	Total		Physician		Midwife		Others		Not Stated
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths
1963	31	4.5	28	4.1	—	—	3	200.0	—
1962	42	5.9	38	5.5	1	4.7	3	198.7	—
1961	50	6.8	43	6.1	3	13.4	4	272.1	—
1960	41	5.6	35	4.9	2	8.6	3	173.4	1

TABLE 4—MATERNAL DEATHS BY OCCURRENCE, BY CAUSE WITH PERCENTAGES, KENTUCKY, 1963-1961

Cause	1963		1962		1961	
	Deaths	Percent	Deaths	Percent	Deaths	Percent
TOTAL	23	100.0	29	100.0	40	100.0
Sepsis of pregnancy, childbirth and puerperium	7	30.5	5	17.2	6	15.0
Toxemias of pregnancy and the puerperium	4	17.4	6	20.7	12	30.0
Hemorrhage of pregnancy and childbirth	5	21.7	4	13.8	10	25.0
Abortion without mention of sepsis or toxemia	—	—	2	6.9	1	2.5
Abortion with sepsis	1	4.3	2	6.9	2	5.0
Other complications of pregnancy, childbirth and the puerperium	6	26.1	10	34.5	9	22.5

TABLE 4a—MATERNAL DEATHS BY OCCURRENCE, BY CAUSE WITH PERCENTAGES, KENTUCKY, 1963-1961

Cause	1963		1962		1961	
	Deaths	Percent	Deaths	Percent	Deaths	Percent
TOTAL	31	100.0	42	100.0	50	100.0
Sepsis of pregnancy, childbirth and puerperium	7	22.6	5	11.9	6	12.0
Toxemias of pregnancy and the puerperium	4	12.9	6	14.2	12	24.0
Hemorrhage of pregnancy and childbirth	5	16.1	4	9.5	10	20.0
Abortion without mention of sepsis or toxemia	—	—	2	4.8	1	2.0
Abortion with sepsis	1	3.2	2	4.8	2	4.0
Other complications of pregnancy, childbirth and the puerperium	14	45.2	23	54.8	19	38.0

TABLE 5—MATERNAL DEATHS BY OCCURRENCE, SHOWING AUTOPSIES OBTAINED WITH PERCENTAGES, KENTUCKY, 1963-1961

	1963		1962		1961	
	Deaths	Percent	Deaths	Percent	Deaths	Percent
TOTAL	23	100.0	29	100.0	40	100.0
Autopsies obtained	8	34.8	10	34.5	7	17.5
Autopsies not obtained	14	60.9	13	44.8	18	45.0
Autopsies not stated	1	4.3	6	20.7	15	37.5

TABLE 5a—MATERNAL DEATHS BY OCCURRENCE, SHOWING AUTOPSIES OBTAINED WITH PERCENTAGES, KENTUCKY, 1963-1961

	1963		1962		1961	
	Deaths	Percent	Deaths	Percent	Deaths	Percent
TOTAL	31	100.0	42	100.0	50	100.0
Autopsies obtained	11	35.5	16	38.1	8	16.0
Autopsies not obtained	19	61.3	18	42.9	26	52.0
Autopsies not stated	1	3.2	8	19.0	16	32.0

TABLE 6—MATERNAL DEATHS BY OCCURRENCE, BY AGE GROUP WITH RATES, KENTUCKY, 1963-1961

	1963		1962		1961	
Age Group	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total—all ages	23	3.3	29	4.1	40	5.6
15-19	4	3.1	2	1.6	5	3.7
20-24	3	1.2	3	1.2	10	4.1
25-29	3	2.0	7	4.5	8	5.0
30-34	2	2.2	7	7.1	8	7.9
35-39	5	9.5	10	18.1	6	10.2
40 and over	6	33.4	—	—	3	15.6

TABLE 6a—MATERNAL DEATHS BY OCCURRENCE, BY AGE GROUP WITH RATES, KENTUCKY, 1963-1961

	1963		1962		1961	
Age Group	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total—all ages	31	4.5	42	5.9	50	6.8
15-19	5	3.9	3	2.3	7	5.2
20-24	4	1.7	4	1.7	12	5.0
25-29	3	2.0	12	7.7	11	6.9
30-34	5	5.5	8	8.2	9	8.9
35-39	7	13.3	15	27.2	7	11.9
40 and over	7	39.0	—	—	4	20.8

TABLE 7—MATERNAL DEATHS BY OCCURRENCE, BY PARITY WITH RATES, KENTUCKY, 1963-1961

	1963		1962		1961	
Parity	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total	23	3.3	29	4.1	40	5.6
0	4	2.1	4	2.2	9	4.8
1-3	5	1.5	7	1.9	13	3.5
4-6	6	5.8	8	7.3	10	9.1
7 and over	7	16.5	2	4.5	1	2.2
Not Stated	1	*	8	*	7	*

*Rate not computed as an accurate base was indeterminable.

TABLE 7a—MATERNAL DEATHS BY OCCURRENCE, BY PARITY WITH RATES, KENTUCKY, 1963-1961

	1963		1962		1961	
Parity	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total	31	4.5	42	5.9	50	6.8
0	7	3.7	5	2.7	11	5.9
1-3	8	2.3	13	3.6	15	4.0
4-6	7	6.8	8	7.3	15	13.7
7 and over	8	19.1	3	6.7	2	4.4
Not Stated	1	*	13	*	7	*

*Rate not computed as an accurate base was indeterminable.

TABLE 8—MATERNAL DEATHS BY OCCURRENCE, BY ATTENDANT AT LABOR, KENTUCKY, 1963

Attendant	Number of Deaths
Total	23
Physician	18
Midwife	1
Other	2
No labor or attendant unknown	2

TABLE 8a—MATERNAL DEATHS BY OCCURRENCE, BY ATTENDANT AT LABOR, KENTUCKY, 1963

Attendant	Number of Deaths
Total	31
Physician	26
Midwife	1
Other	2
No labor or attendant unknown	2

TABLE 9—MATERNAL DEATHS BY OCCURRENCE, BY WEEKS GESTATION WITH RATES, KENTUCKY, 1963

	Deaths	Rate
Weeks Gestation	23	3.3
Under 20	1	625.0
20-27	1	28.7
28-31	—	—
32-35	3	21.9
36	2	5.0
37-39	1	1.5
40 and over	12	2.2
Unknown	3	319.1

TABLE 10—MATERNAL DEATHS BY OCCURRENCE, BY PREVENTIVENESS WITH PERCENTAGES, KENTUCKY, 1963

Preventiveness	Number	Percent
Total Deaths	23	100.0
Preventable:	18	78.3
By attendant	1	4.3
By hospital	—	—
By patient	7	30.5
By attendant and patient	8	34.8
By hospital and patient	2	8.7
Unpreventable	4	17.4
Preventiveness unknown	1	4.3

TABLE 11—MATERNAL DEATHS BY OCCURRENCE, BY TYPE, OF OUTCOME WITH PERCENTAGES, KENTUCKY, 1963

Type of Outcome	Numbers*	Percent
Total Deaths	23	100.0
Liveborn:	14	61.0
Full term	12	52.3
Premature	2	8.7
Stillborn:	6	26.1
Full term	4	17.4
Premature	2	8.7
Incomplete abortion	1	4.3
Undelivered:	2	8.6
Full term	1	4.3
Premature	1	4.3
Outcome unknown	1	4.3

*Number totals 24 as one patient had twins, full term, one liveborn, one stillborn.

TABLE 9a—MATERNAL DEATHS BY OCCURRENCE BY WEEKS GESTATION WITH RATES, KENTUCKY 1963

	Deaths	Rate
Weeks Gestation	31	4.5
Under 20	2	1,250.0
20-27	2	57.3
28-31	2	32.7
32-35	3	21.9
36	2	5.0
37-39	1	1.5
40 and over	13	2.4
Unknown	6	638.3

TABLE 10a—MATERNAL DEATHS BY OCCURRENCE, BY PREVENTIVENESS WITH PERCENTAGES, KENTUCKY, 1963

Preventiveness	Number	Percent
Total Deaths	31	100.0
Preventable:	22	71.0
By attendant	1	3.2
By hospital	—	—
By patient	8	25.8
By attendant and patient	10	32.3
By hospital and patient	3	9.7
Unpreventable	7	22.6
Preventiveness Unknown	2	6.4

TABLE 11a—MATERNAL DEATHS BY OCCURRENCE, BY TYPE OF OUTCOME WITH PERCENTAGES, KENTUCKY, 1963

Type of Outcome	Number*	Percent
Total deaths	31	100.0
Liveborn:	17	54.8
Full term	14	45.2
Premature	3	9.6
Stillborn:	8	25.8
Full term	4	12.9
Permature	4	12.9
Incomplete abortion	2	6.5
Undelivered:	4	12.9
Full term	2	6.5
Premature	2	6.5
Outcome Unknown	1	3.2

*Number totals 32 as one patient had twins full term, one liveborn, one stillborn.

Recommendations, Reference Committee No. 4

The committee reviewed the report of the Maternal Mortality Study Committee. "Mr. Speaker, I move the adoption of this section of the report." (The motion was seconded and carried.)

Perinatal Mortality and Morbidity Study Committee

Guy C. Cunningham, M.D., Ashland, Chairman

The Perinatal Mortality and Morbidity Study Committee met this year on March 3. We reviewed our report to the 1965 House of Delegates and opened discussion on the major portions therein.

A discussion followed and everyone present seemed to agree with the action initiated by the introduction of the resolution by Hollis Johnson, M.D., of Jefferson County, to put the PKU screening program on a voluntary basis. (We would like to call your attention to a more detailed report on PKU and other inborn error of metabolism to appear later in the report.)

The next order of business on the agenda was the committee's discussion and attitude towards Premature and Newborn Training Centers in the state of Kentucky. This as mentioned in the committee's report for 1965, was thought to be a healthy move in actively aiding the lowering of the Perinatal Mortality and Morbidity in our commonwealth. In 1965, this committee recommended that serious consideration be given to the establishment of Premature and Newborn Training Centers in the state of Kentucky, particularly those which might be associated with either or both of the two medical schools for training student nurses.

At this time we would like to further suggest that in addition to training student nurses, if such centers can be established through the cooperation of the State Health Department, the KMA, and the two

medical centers involved, one might also enlarge the program to include Licensed Practical Nurses or Aides interested in this field and also the possibility of further post-graduate education along these lines for physicians wishing to participate. This would naturally be done on a voluntary basis and the exact detailed arrangements for such centers would be under the jurisdiction of the two medical schools of our state plus the Department of Maternal Infant, Preschool Services of the Department of Health.

Doctor Robert Bergie, who is in charge of the Premature Newborn Nurseries at the University of Kentucky, spoke in favor of this type of training but that the details would have to be worked out in conjunction with both the Medical School at the University of Louisville and also, with Doctor Judith Hood of the Department of Health of the State of Kentucky. Doctor Hood was present at the meeting, and stated that her Department of Maternal Infant, and Preschool Services was still very much interested in the possibility of Premature and Newborn Training Centers in the state and would implement the action of this committee in any way that she possibly could. We would therefore like to recommend that this committee go on record as being in favor of continued efforts to establish Postgraduate Training in Premature and Newborns for the nursing personnel and interested physicians.

The next order of business was a brief summary and discussion of reducing Infant Mortality. This discussion was by the chairman, Doctor Cunningham, who patterned his remarks along the lines of the suggested approaches of reducing Infant Mortality by the committee on Maternal and Child Care of the American Medical Association. Following is a brief review of these remarks: see ATTACHMENT A.

The committee recommended that insofar as possible, we try to follow these primary and secondary preventive measures.

The next order of business was a presentation by one of our invited guests, Doctor C. Charlton Mabry, Assistant Professor of Pediatrics at the University of Kentucky, on "Detection of Treatable Neurometabolic Disorders in the Neonate" with a few comments by the author. The following is a resume of Doctor Mabry's presentation to the committee: see ATTACHMENT B.

The committee felt that this report by Doctor Mabry was very enlightening and helped to point out the progress and the needs for mass screening for hereditary metabolic diseases.

The chairman of the committee, Doctor Cunningham, noted in closing remarks on Metabolic Disorders that at the present time screening newborns for hereditary metabolic diseases could best be summed up along the lines published by Charles R. Scriver, M.D., in the Pediatric Clinics of North America, when he said, "progress in medical care has brought mass screening for hereditary metabolic disease in the neonatal period to a position of prominence. Screening programs of today are providing diagnostic services, as well as revealing deficits in our knowledge of this group disease. Because the techniques for screening and the designs of the application to the population are improving and changing steadily, it is not advisable to designate any one technique as the 'best' screening method at present. For this reason, encouragement of mass screening should be liberal and foresighted. Careful review of the limits of the screening methods, and the limits of our knowledge of hereditable metabolic disease should direct our decisions on who should be screened and when and how this is to be accomplished. There may be need for a complex structure within the community to meet all the needs of an adequate screening program. In addition to the laboratory facilities and the personnel required for the screening procedure itself, there should be supplementary and specific laboratory facilities to confirm the diagnosis. There should also be facilities to insure continuing medical care of the patient once identified. Assurance should be sought from industry that the complex modification of environment which may be required to counteract the effects of genetic mutation will be available to the medical consumer."

ATTACHMENT A

The AMA's Committee on Maternal and Child Care analyzed some common interpretations of infant mortality rates as they relate to health levels. The report concluded that comparing mortality statistics among nations with varying types of populations is *not* a reliable procedure. They indicated, however, that these crude rates are useful for determining trends within specific geographic and cultural boundaries.

As the infant mortality rate gradually began to level off in the 1950's greater emphasis was directed against the loss of infant life during late pregnancy (fetal mortality) and during the first week of life (early neonatal mortality). For more accurate analysis, deaths during these two periods were combined and termed "perinatal mortality."

The AMA Committee on Maternal and Child Care believes infant mortality can be significantly reduced, especially that of the perinatal period by the total application of present obstetrical and pediatric knowledge and methodology.

A brief discussion followed in regards to the following:

I. Social Factors in Obstetrics
II. Sociobiological Interrelationships
III. Illegitimacy
IV. Socioeconomic Status
V. Age-Parity Patterns
VI. Maternal Health Factors
VII. Prenatal Care Influences

S. H. Clifford (New England J. of Med. 1964) concludes that "the separation of the relatively few high-risk pregnancies from the mass of normal pregnancies for special and intensive study and care, including hospitalization, may prove to be a successful method of significantly lowering perinatal mortality and morbidity below the present frozen level. High-risk babies have high-risk mothers is another way of looking at the problem. Evidence which now is accumulating seems to indicate a definite correlation between certain maternal conditions and increased infant mortality.

FACTORS CORRELATING WITH HIGH RISK MOTHERS AND INFANTS

I. Family History and Background
II. Medical History of Mother
III. Previous Obstetrical History of Mother
IV. Present Pregnancy
V. Labor and Delivery
VI. Placenta
VII. Neonatal

I. FAMILY HISTORY AND BACKGROUND
- Presence of Mutant Genes
- Central Nervous System Disorders
- Previous Defective Siblings
- Parental Consanguinity
- Intrafamilial Emotional Disorders
- Low Socioeconomic Status
- Allergy
- Race

II. MEDICAL HISTORY OF MOTHER
- Diabetes
- Hypertension
- Cardiovascular or Renal Disease
- Thyroid Disease
- Idiopathic Thrombocytopenic Purpura
- Menstrual History
- Radiation
- Short Stature
- Nutritional Deficiencies
- Work History (Manual Labor)
- Smoking Habits

III. PREVIOUS OBSTETRICAL HISTORY OF MOTHER
- Miscarriage Preceding Current Pregnancy
- Previous Neonatal Loss
- Prolonged Infertility
- Size of Infants
- Toxemia in Previous Pregnancy
- High Parity
- Excessive Weight Gains

IV. PRESENT PREGNANCY
- Maternal Age (18 or) 38
- Multiple Births
- Illegitimate Pregnancy
- Medications
- Radiation
- Fetal-Maternal Blood Group Incompatibility
- Absence of Prenatal Care
- Viral Diseases, including Rubella, in First Trimester
- Polyhydramnios
- Pyelonephritis
- Oligohydramnios
- Diabetes
- Toxemia

V. LABOR AND DELIVERY
- Prematurity
- Postmaturity-Dysmaturity
- Precipitate or Prolonged
- Breech or Cesarean Delivery
- Anesthesia (Prolonged)
- Low Apgar Score—5 minutes

VI. PLACENTA
- Massive Infarction
- Amnion Nodosum
- Placentitis

VII. NEONATAL
- Prematurity
- Umbilical Artery Aplasia
- Jaundice (Billirubin Level)
- Severe Dehydration Hyperosmolarity and Hypernatremia
- Head Size
- Infection
- Hypoxia
- Convulsions
- Failure to Regain Birth Weight by Ten Days
- Manifest Congenital Defects
- Disproportion Between Weight or Length and Gestational Age
- Survival Following Meningitides
  - Encephalopathies and Traumatic
  - Intracranial Episodes

PRIMARY PREVENTION

Deaths during the neonatal period now constitute close to 75 percent of all infant deaths. The four main complications are:

1. Prematurity
2. Congenital malformations
3. Anoxia
4. Birth trauma

These complications account for 90 percent or more of these deaths.

IMPROVING PRENATAL CARE
GENERAL RECOMMENDATIONS

Any inquiry into the complex diversified problems involved in reducing perinatal mortality requires many approaches. Extensive investigation and experimentation is necessary before a major improvement is possible. However, until new preventive measures are developed, a gradual reduction in infant mortality is a practical goal. A continuous decline in perinatal deaths can be accomplished if present knowledge and accepted techniques are widely applied.

The AMA Committee on Maternal and Child Care therefore suggests that the following general recommendations be instituted whenever applicable.

FOR PRIMARY PREVENTION

1. Improve methods of early identification of "high-risk" mothers.
2. Identify all "high-risk" newborns by means of Apgar ratings and other techniques.
3. Improve infant resuscitation techniques.
4. Reduce infections in newborns by known methods.
5. Extend the present "know how" on the care of prematures.
6. Evaluate present prenatal-care facilities and practices at the local level and institute remedial measures wherever necessary.
7. Promote participation in prenatal and expectant-parent classes and prenatal clinics.
8. Use caution in prescribing diagnostic x-ray procedures and drugs for potential mothers.
9. Discuss contraception and family planning practices routinely with patients in mutually acceptable terms.
10. Extend postgraduate education programs in obstetrics and pediatrics.

FOR SECONDARY PREVENTION

1. Promote the organization of perinatal mortality study committees in all hospitals and communities.
2. Calculate annual premature, infant, fetal, perinatal, neonatal, and postneonatal rates at all levels of investigations.
3. Compare the rates with other local, state, and hospital committees.
4. Investigate all infant deaths at the local level to determine preventability factors.
5. Implement any needed corrective measures after the analysis and evaluation is accomplished.
6. Match and evaluate the neonatal-death and birth-certificate data.
7. Analyze all fetal-death certificates.
8. Evaluate the local hospital and prenatal-care services according to the standards recommended by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.
9. Encourage organized research projects and contribute self-initiated research to the literature.

ATTACHMENT B.
PORTION OF MINUTES OF THE PERINATAL MORTALITY COMMITTEE MEETING OF THE KENTUCKY MEDICAL ASSOCIATION.
MARCH 3, 1966

At the outset, I would like for it to be clear that I have no rigid feelings as to whether or not a so-called PKU testing law should be passed in Kentucky at this time. The fact that the law has already passed the house (Kentucky Lower House 82-2) and is pending in the Senate makes the whole problem of screening for inborn errors of metabolism pertinent at this time. There are, of course, good reasons why the detection of the newly born phenylketonuric individual is important. If he is treated from earliest infancy he will be normal or near normal, and the law on testing all infants for this disease then could be justified for humane reasons. The second reason is that if left untreated these infants almost always are severely defective with IQ's of 10-30. They become totally dependent on others for their care and, in many instances, become virtual "vegetables". A quick estimate of what a patient with this disease, who is institutionalized at Frankfort State Hospital and School, would cost the state can be made by dividing the total operating costs of the Frankfort State Hospital and School per year by the number of patients; this gives a figure of about $1900 per patient per year. So, if the patient were institutionlized there at age 6 and survived for 25-30 years, which is par for a patient with this disease, then each case in Kentucky undoubtedly would cost us at least $50,000. When you consider that there are 70,000 births per year in Kentucky, or about 5,800 per month, then there should be seven of these

babies (incidence is 1/10,000 births) born in Kentucky each year. It is estimated that successful early detection and adequate care of one patient would amortize the investment of mass screening for PKU —if it were done efficiently and at a central location.

Now, I would like to give an overview of the problems and possibilities for the early detection of other neuro-metabolic disorders. Of the 70,000 babies born in Kentucky each year about 3 percent (or 2,100) will be moderately to severely retarded and dependent upon others for their support and care. Of this 2,100 it is estimated that at least a quarter to one-third are due to hereditary disorders —mostly, the so-called inborn errors of metabolism, the following (Table 1) is a list of inborn errors of metabolism associated with mental subnormality and neurologic deficits:

TABLE 1
INBORN ERRORS OF METABOLISM ASSOCIATED WITH MENTAL SUBNORMALITY

I. Disorders of Protein or Amino Acid Metabolism
- Albinism
- Argininosuccinic Aciduria (Allan-Dent Disease)
- Citrullinuria
- Cystathioninuria
- Familial Hyperprolinemia
- Hartnup Syndrome
- Histidinemia
- Honocystinuria
- Hydroxprolinemia
- Hyperglycinemia
- Joseph's Syndrome
- Maple Syrup Urine Disease
- Methioninemia
- Oast-House Disease
- Phenylketonuria
- Sex-Linked Microcephaly and Spastic Diplegia
- Uraciluria

II. Disorders of Carbohydrate Metabolism
- Fructose Intolerance (Fructosemia)
- Galactosemia
- Leucine-Induced Idiopathic Hypoglycemia
- Morquio Ullrich's Disease
- Sucrosuria

III. Disorders of Lipid Metabolism
- Familial Amaurotic Idiocies
  - a. Infantile form—Tay Sachs Disease
  - b. Late Infantile form—Bielschowsky's Disease
  - c. Juvenile form—Spielmeyer-Vogt's Disease (Batten-Mayou Disease)
  - d. Adult form—Kuf's Disease
- Gargoylism
- Gaucher's Disease
- Hereditary Dystopic Lipidosis (angiokeratoma corporis diffusum universale)
- Leukodystrophies
  - a. Familial Infantile Metachromatic Leukoencephalopathy
  - b. Krabbe's Disease (Globoid Cell Leukodystrophy)
  - c. Leukodystrophy with Rosenthal Fiber Formation
  - d. Sulfatide Lipidosis (Scholz-Greenfield Disease)
- Neimann-Pick Disease

IV. Disorder in Trace Metals Metabolism
- Huntington's Chorea

This, of course, is a long list of disorders and the central defect is now known in many. There is treatment for only a few, so we should focus our attention and efforts on detection in the neonate of those neuro-metabolic disorders for which we have some form of treatment and on those in which detection, using micro amounts of biologic fluid, can be made. Table 2 lists eleven of these disorders which could be detected if blood (or urine) was obtained at the time of discharge from the hospital nursery and again at the first well baby check-up. (Table 2).

TABLE 2
INBORN ERRORS OF METABOLISM DETECTABLE BY AUTOMATION

4 days

Disease	Fluid	Substance
1. PKU	Blood or Urine	Phenylalanine or Phenylketones
2. Galactosemia	Blood & Urine	Galactose & Enzyme Deficiency
3. Hypoglycemia	Blood	Glucose
4. Histidinemia	Blood	Histidine
5. Tyrosinosis	Blood	Tyrosine
6. Hyperglycinemia	Blood	Glycine
7. Maple Syrup Urine Disease	Blood & Urine	Blood - valine, leucine, isoleucine Urine - ketocids
8. Homocystinuria	Urine	Homocystine
9. Cretinism	Blood	PBI

3-6 weeks

Disease	Fluid	Substance
1. PKU	Blood or Urine	Phenylalanine or Phenylketones
2. Galactosemia	Blood & Urine	Galactose & Enzyme Deficiency
3. Hypoglycemia	Blood	Glucose
4. Histidinemia	Blood & Urine	Histidine & Indole
5. Tyrosinosis	Blood & Urine	Tyrosine
6. Hyperglycinemia	Blood	Glycine
7. Maple Syrup Urine Disease	Blood & Urine	Blood - valine, Leucine, isoleucine Urine - ketoacids
8. Homocystinuria	Urine	Homocystine
9. Wilson's	Blood	Ceruloplasmin

Next let us consider the technical aspects of detection. Our largest experience with mass screening for an inborn error of metabolism has been with phenylketonuria and the first successful mass screening took place in Massachusetts from July 1962 to July 1963 and of the 400,000 babies born in Massachusetts that year there were about 20 instances of phenylketonuria that were detected.

The test used in that program was the Guthrie Inhibition Assay, a bacteriologic assay which gives you a positive result if the blood phenylalanine is greater than 4 mg %. The Guthrie Inhibition Assay has been used by almost all laboratories for mass screening since that time; however, just this past year, the flurometric method of McCann and Robins for measurement of blood phenylalanine has been automated. The method of automation is continuous flow wet chemistry and was developed by Doctors John Hill and George Sumner at Chapel Hill, North Carolina. Importantly, this method gives you quantitative measurement and the specimen test rate can be as rapid as 60/hr. At present, this is the method that is being used by the State Health Department in Raleigh, North Carolina, and in North Carolina they have about 100,000 babies born each year. I feel sure that other laboratories will begin to use the automated chemical method rather than the Guthrie Bacteriologic Assay method because it will be: 1. quantitative, 2. relatively trouble free for laboratory personnel, 3. cheaper, and 4. the same equipment can be used to test blood for other inborn errors for metabolism. Some tests are imminent

at this time. The cost for this and the Guthrie testing are in the order of .06 to 1 cent per test; the over-all administration and overhead costs of secretarial work, technicians, laboratory space, etc., is in the order of 50 cents per test. All of these tests will be handled if the specimens are collected on filter paper (the simplest way a specimen can be collected) and mailed to a central laboratory where there is continuing testing experience.

The next phase of mass screening is concerned with reporting and, like that of the actual performance of the test, I feel this portion of the testing cycle should be automated. This could be done by preparing IBM cards with individual patient's names, referring doctor and the county of origin; the data would be stored in a computer, re-assembled weekly, and reported to computer feedouts in every county health department once weekly. This would lower overhead costs. The computer techniques used would be those that are to be used in our Central Clinical Laboratory here in University Hospital beginning in early 1967. The experience in most states that already are performing mass screening is that the false positives to true positives ratio is about 10-1; thus, there should be satisfactory follow-up resources for the doctor in case he has a baby who has a blood phenylalanine concentration greater than 4 mg %. To date, the few cases that have originated from our voluntary testing program have been referred to either Doctor B. Andrews at the Louisville Children's Hospital or to me here at University Hospital. These cases have been evaluated very quickly. In all instances to date, these have come from premature babies with immature livers who had blood levels of phenylalanine in the order of 4 to 10 mg %; this is a normal phenomena for the low birth weight infant with an immature liver. Our working criteria for confirmation of the diagnosis of phenylketonuria in the newborn are as follows:

1. A blood phenylalanine greater than 5 mg %
2. A blood tyrosine less than 5 mg %
3. A urine phenylalanine greater than 100 micrograms/ml of urine
4. Orthohydroxyphenylacetic acid greater than 10 micrograms/ml of urine

Additional clinical criteria are informally applied. These seem to be the criterias that others are using in other states.

In summary, I would like to say that detection of treatable hereditary diseases is going to come, and the methods for doing this are already available or imminent within the next five years. Some would complain that this is unequal progress and that similar amounts of money and effort ought to be invested for less rare disorders. I would like to point out, though, that even though all of these diseases are rare and that the incidence may range from 1 in 500 to 1 in 40,000, in the aggregate they constitute a significant portion of morbidity and mortality both for children and adults.

I don't see that the testing necessarily has to have the "bite of the law", and, undoubtedly, should there be a law it cannot be implemented unless there is a great deal of continuing education concerning this burgeoning phase of medicine. I do feel though that it is mandatory, both for quality control and for financial reasons, that the testing be limited to one or only a few laboratories. Follow-up resources for presumptive cases should be continuously available to all physicians in the state.

Recommendations, Reference Committee No. 4

The committee reviewed the report of the Perinatal Mortality and Morbidity Study Committee. "Mr. Speaker, I move the adoption of this section of the report." (Motion seconded; carried.)

Physical Medicine and Rehabilitation Committee

William K. Massie, Jr., M.D., Lexington, Chairman

This committee met on February 10, 1966, to outline the objectives and to review the recommendations of the previous year. On June 2, 1966, it had its final meeting. The objectives of the committee for 1965-1966 are listed and discussed below.

1. Proposed alteration of the Workmen's Compensation Law. The objective of the present law is to provide remuneration for on-the-job injury and resulting disability. The responsibility for rehabilitation, retraining, and replacement is not an integral part of the law. Disability is determined more by the effect of the injury on job performance than on physical impairment. Hence, a worker unable to return to a previous *specific* occupation may be determined permanently and totally disable for *any* occupation. PL 89-97, Section 303, provides social security remuneration for an employee already receiving workmen's compensation payments but forced by disability to remain out of work for twelve consecutive months. Such dual compensation may supply an insurmountable barrier to rehabilitation and reemployment. The committee, therefore, initiated and supported a proposed rehabilitation amendment, provided by KMA Legal Counsel at the request of the Legislative Council, to be presented to the 1966 Kentucky Legislature. After copies had been presented to the Commissioner of Labor, President of the Coal Operators Association, and the Committee of Insurance Adjustors, it seemed the consensus that presentation to the 1966 Legislature without more preparation would meet with failure. Plans were, therefore, made to hold a conference in the fall of 1966 at which specific steps would be outlined for the preparation and presentation of another amendment at the next Legislature.

2. Report of the Sub-Committee on Disability and Physical Impairment. It is mandatory if disability evaluations are to be based primarily on physical impairment rather than job capability as discussed above, that some yardstick for this rating which would utilize the many variables inherent in such a rating and be acceptable to the rating physicians throughout the commonwealth and amendable to close agreement among physicians presented with a given patient should be available. This sub-committee has formulated procedure of action with this objective in mind, in consultation with computer experts at Spindletop Research, as follows:

1. A sample (simple) impaired patient will be subjected to examination.
2. Finding: (a) physical impairment, (b) effect on efficiency in each job within patient's capability, (c) effect under all weather conditions, (d) effect of socio-economic factors, (e) effect of age, (f) effect of educational status.

Each will be subjected to analysis by a specialist in this field.

3. All findings will be programmed and fed to a computer.
4. The computer ratings will then be compared to ratings provided by a panel of examining M.D.'s not previously informed as to the study.
5. The results will be formulated in a paper to be presented at national meetings, i.e., American Academy of Orthopaedic Surgery.
6. A committee on a national scale could enlist men with specialized interests and training to outline a program for only small areas which when assembled and computerized could serve as basis for disability ratings nationally. This is now in the planning stage.

3. A simple directory of available rehabilitation facilities within the state is being edited for publication in the KMA Journal.

In summary, the committee would like to re-

"'Tranquilizer' is not a good word"[1]

"THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there are differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert.

References: 1. Simpson, G.M.: Postgrad. Med. *39*:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. *115*:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: *65*:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. *25*:553, 1961. 7. Sainz, A.: Psychosomatics *5*:167, 1964.

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LOMOTIL®

tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

tackles the problem of diarrhea directly

Effectiveness—Physiologic evidence indicates that Lomotil acts directly on the smooth muscle of the bowel to lower motility and control diarrhea. This action is unsurpassed in promptness and efficiency.

Convenience—Lomotil is available as small, easily carried, virtually tasteless tablets and as a pleasant, fruit-flavored liquid.

Versatility—The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:

• Functional hypermotility • Acute infections • Malabsorption syndrome • Drug therapy • Gastroenteritis and colitis • Irritable bowel • Regional enteritis • Ileostomy • Ulcerative colitis • Food poisoning

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)

Adults: 2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

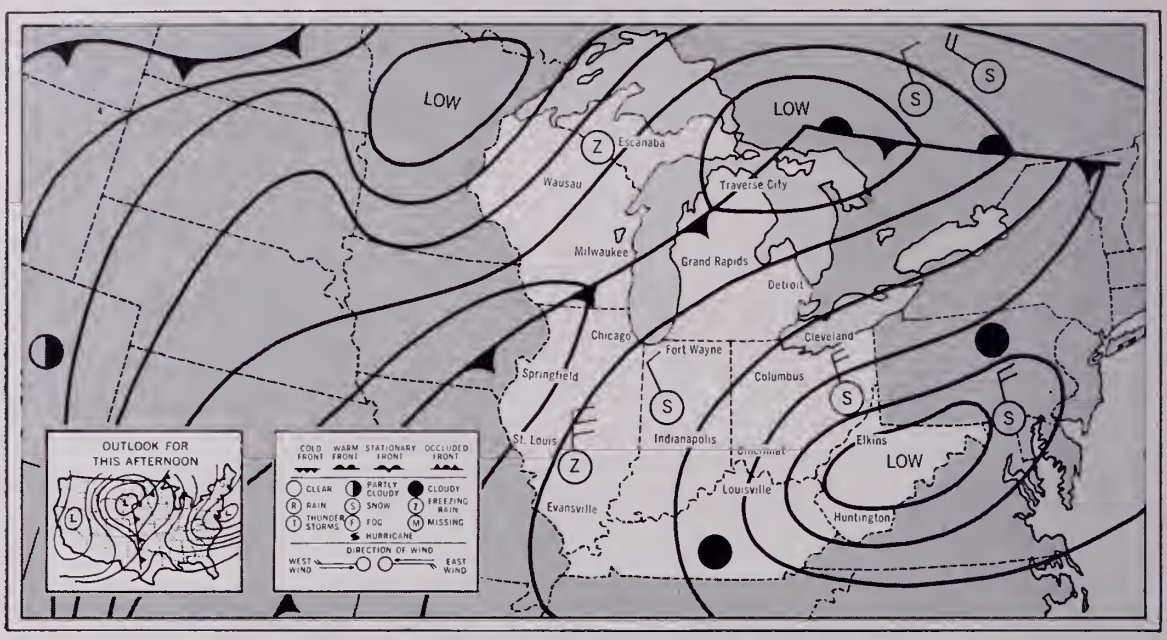
Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. *Side effects:* Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. *Precautions:* The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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emphasize the paramount importance of rehabilitation, re-training, and re-employment in the consideration of every injury if we are to reduce the increasing list of permanently and totally disabled workers.

Recommendations, Reference Committee No. 4

This report was reviewed by the Reference Committee. "Mr. Speaker, I move the adoption of this section of the report." (The motion was seconded and carried.)

Tuberculosis Committee

Joseph Humpert, M.D., South Fort Mitchell, Chairman

The Tuberculosis Committee met at the KMA Headquarters Office on April 7 and had as their guests Stuart Lauder, M.D., State Department of Health, Frankfort; Mr. Thomas Layton, Executive Director, State TB Commission; and Mr. Thomas P. Summers, Executive Director, TB and Respiratory Disease Association, Louisville.

Members of the committee held considerable discussion on the TB Eradication Program under way in Kentucky. It was reported that 137,000 school children and personnel in Kentucky have been tested thus far since the program got under way in September 1964. Of those tested, 2,600 positive reactors resulted among the school children and 729 among the school personnel.

Doctor Lauder stressed the importance of follow-up of TB cases and pointed out that the Department of Health is in the process of gradually establishing county registers in all county health departments throughout the state. Thus far, 71 counties have these files available.

It was revealed that hospitals in the state are reporting more TB cases than ever before and that these cases are moderately or far advanced. The committee discussed the 1964 report of the Council on Allied Professions and Related Groups to the KMA House of Delegates in which it was recommended that if in the state of Kentucky in the near future there is an appreciable increase in the incidence of TB that legislation be initiated to require TB testing in children similar to the Immunization Law now in effect. Mr. Summers reported there is a 61-case increase during the first quarter of 1966 over the same period in 1965. It is recommended that the committee again go on record as endorsing the school tuberculin testing program instigated by the American School Health Association and recommends endorsement of this program by the KMA House of Delegates through the Council on Allied Professions and Related Groups and the Board of Trustees. Specifically, it is recommended that all grades, one through twelve, be tuberculin tested every two years with follow-up of all positive reactors, and their contacts, and treatment of all active disease, including recent tuberculin converters.

Members also heard a report by Mr. Layton on the state TB Hospital program. He said unless more TB is detected, there will be more and more pressure to close the TB Hospitals. It was pointed out that some groups should consider using the empty beds in these hospitals for the treatment of chronic chest cases for the medically indigent as the cost difference is very little to have the bed occupied as opposed to having it empty.

A report was made on the second Campbell House Conference held in Lexington and considerable discussion resulted. It was anticipated that the Governor, in the very near future, will convene a group in the state and develop a more enthusiastic attack on TB control.

Concern was expressed to the prevalence of TB among the elder citizens of Kentucky in that a more intensive program of detection should be undertaken to discover these cases and treat their many contacts. This committee recommends for approval of the KMA House of Delegates through the Council on Allied Professions and Related Groups and the Board of Trustees that KMA recommend that the State Department of Health require that routine chest x-raying of all initial admissions to nursing homes should be a requirement for certification for accreditation of the nursing home by the State Board of Health.

COUNCIL ON ALLIED PROFESSIONS AND RELATED GROUPS
Guy C. Cunningham, M.D., Ashland
Ellis A. Fuller, Jr., M.D., Louisville
Joseph Humpert, M.D., South Fort Mitchell
Condict Moore, M.D., Louisville
Walter L. O'Nan, M.D., Henderson
Melvin J. Weber, M.D., Ludlow
William K. Massie, Jr., M.D., Lexington, Chairman

Board of Trustees Recommendations

The council's report was approved by the Board with the following exceptions:

In reference to the report of the Cancer Coordinating Committee, the Board recommends that in addition to approval of the cervical cancer screening program by the county board of health and the county medical society, there should be a request from the patient's private physician that this be done.

In reference to the report of the Industrial Medicine Committee, although not opposing the principle health service for employees of the state of Kentucky (Item #5, Page 14 of report), the Board recommends to the House of Delegates that the particular recommendations of the Committee and Council contained in Item #5 be disapproved. The Board accepts Item #2 on Page 14 with the notation that other proposals have been made on the name of this committee. In regard to the policy statement in the second paragraph, Page 15, the statement is approved with the observation, however, that visual assessment may include optometric refraction which is by law not confined to the practice of medicine.

Recommendations, Reference Committee No. 4

The committee reviewed the report of the Tuberculosis Committee and recommends its adoption with the exception of paragraph four, being the last paragraph on page 41, and paragraph five, being the second paragraph on page 42.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of the report of the Council on Allied Professions and Related Groups as a whole, as amended. (Motion seconded; carried.)

Resolution D
Jefferson County Medical Society

PREAMBLE

We realize that the Kentucky Medical Association along with active county medical societies has been instrumental in the developing of hospital planning programs, medical student recruitment, nursing education, hospital and nursing home planning, and community care facilities or clinics. We realize also that KMA has been interested in and active with state health agencies such as, the Kentucky State Plan for construction and modernization of hospital and medical facilities.

Even though the above are necessary and continuing, we believe these, along with other factors, point up a greater need for the medical profession to demonstrate the kind of hard work and dedicated interest which will provide leadership in forward-looking and imaginative plans regarding tomorrow's community medicine. We believe the need is now for physicians to be more than just included in the thinking of third party plans but to demonstrate

their willingness to provide aggressive leadership in any plan which involves patient care.

The medical profession should increase its efforts to identify itself with the total medical care problems of society. It should study—and try to understand—these problems. It should assume leadership in the formulation, with others, of solutions to these problems. It should offer proposals which recognize the valid interest of both the public and the profession. It should inform the public more fully of its existing and projected studies and proposals, and of its increasing concern with problems of mutual interest.

The medical profession in Kentucky should discharge more effectively its responsibility for leadership. The organization and structure of organized medicine should be used to seek ways to provide for the following: a) maximum participation of its members, b) maximum flexibility in responding to immediate and future problems in the scientific, social, and economic aspects of medical care, and c) the encouragement of experimentation and innovation in medical care patterns.

There is some consensus among spokesmen outside of medicine that the medical profession could exercise more effective leadership in the issues with which it has a direct and immediate concern and the profession has frequently seemed not to recognize the value of constructive ideas and leadership offered by other groups. It is then asserted that the profession has not implemented some of its own declarations, and shown disinterest in some issues which are of direct concern to the welfare of patients, thus tending to alienate the profession from social institutions of which the medical profession is a part.

We believe much work remains to be accomplished in the area of basic and continuing medical education, nursing education and refresher courses, distribution of para-medical personnel, as well as the better development of co-ordinated services from hospitals, nursing homes and community-level physician's practice.

Since the Jefferson County Medical Society is concerned with all of these problems, we offer the following resolution.

Resolution

Whereas, It is necessary in this day and time for physicians in every Kentucky community to increase their efforts to identify with the total medical care problems of society and to assume leadership in the formulation, with others, of solutions to these problems. It should offer proposals which recognize the valid interest of both the public and the profession. The data and background information from throughout the state should be co-ordinated and programed by leadership from KMA, therefore

Be It Resolved, That this House of Delegates authorize the Speaker together with the KMA President, to appoint a special ad hoc committee, perhaps to include lay people in addition to physicians, and called the *KMA Study Committee For Improved Community Health,* which would utilize the staff of the State Association along with any other resources available to conduct an on-going study in all areas mentioned above, including the medical needs of citizens at the community level with the goal of developing and recommending programs and types of medical practice, and

Be It Further Resolved, That this special Study Committee of the House of Delegates publish a written report of progress to each member of this House every six months, as well as using every opportunity to inform the medical profession of their purpose and progress in any manner desirable, and

Be It Further Resolved, That a progress report on the work of this Study Committee be submitted to the regular meeting of the KMA House of Delegates in September 1967 for our re-approval of their work or discharge.

Recommendations, Reference Committee No. 4

The committee considered Resolution D as presented by the Jefferson County Medical Society and the committee is in agreement in principle with the resolution. We recommend the adoption of this resolution with the following amendments:

1. In paragraph two, the deletion of the portion of the last sentence which reads "with the goal of developing and recommending programs and types of medical practice."

2. The addition of "AND BE IT FURTHER RESOLVED, the KMA Study Committee for Improved Community Health utilize local community self-study groups consisting of both professional and lay organizations to study local medical problems."

3. That paragraph three be deleted.

4. That an addition be made at the end of paragraph four, "including a cost and feasibility study."

"Mr. Speaker, I move the adoption of this section of the report." (Motion seconded; carried.)

"Mr. Speaker, I move the adoption of the report of Reference Committee No. 4 as a whole." (The motion was seconded and carried.)

I wish to express appreciation to the members of Reference Committee No. 4, James L. Becknell, M.D., Manchester; Kenneth P. Crawford, M.D., Louisville; Robert E. Robbins, M.D., Greenville; and James B. Tolliver, M.D., Whitesburg, and to Mrs. Brock in the preparation of this report.

REFERENCE COMMITTEE NO. 4
James L. Becknell, M.D., Manchester
Kenneth P. Crawford, M.D., Louisville
Robert E. Robbins, M.D., Greenville
James B. Tolliver, M.D., Whitesburg
Fred D. Rainey, M.D., Elizabethtown, Chairman

Following the consideration of the report of Reference Committee No. 4., the Speaker asked Harold B. Barton, M.D., Corbin, chairman of the Kentucky Educational Medical Political Action Committee, to make a report on his organization's activities during the year last past. Following his report, the House of Delegates resumed consideration of the reports of the Reference Committees.

Reference Committee No. 5†

Walter I. Hume, M.D., Chairman
Reports on Medical Service

See Note (†) bottom of column one, page 1122.

Reference Committee No. 5 considered the following:

14. Council on Medical Services
27. Technical Advisory Committee on Indigent Medical Care
12. Page 6, last paragraph thru first regular paragraph on Page 7

Resolutions A, B, C, G, J, K, and L

23. Board of Directors, Kentucky Physicians' Mutual, Inc.
16. Page 2, second paragraph thru top of Page 3, Board action and addendum
31. Advisory Committee to Selective Service
24. Board of Trustees, Rural Kentucky Medical Scholarship Fund

Reference Committee No. 5, meeting in Parlor C of the Kentucky Hotel at 2:00 p.m. on this date, September 19, 1966, discussed in the above order the above items of business referred to it for consideration.

Attendance at the committee hearing was good and discussion was open and spirited, enabling the committee to sample opinions on the various items at some length. The tolerance of the members of this association present in the committee room, as well as the knowledge and enthusiasm which they brought to the various items under discussion, was much appreciated by your committee.

Report of the Council on Medical Services

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the bylaws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Services is presented in the following order:

1. *Actions and recommendations by the council which it undertook on its own initiative.*
2. *Reports of the committees of this council with the council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

The Council on Medical Services has met twice during this associational year, November 18, 1965, and June 9, 1966.

Our first session opened with a general discussion relative to our 1965 report to the House of Delegates and the action taken by the delegates. A few matters had been referred back to our council for implementation and appropriate committees were assigned these referrals for necessary action. The complete results are encompassed in the reports of the committees serving under this council.

Additionally, the council disposed of a number of routine matters and then coordinated the planned programs for the 1965-1966 associational year of the committees reporting to this council. In our discussion of medical services, considerable time was spent reviewing various governmental medical programs including Medicare, PL 89-97, although this specific subject has been assigned to another committee.

Some two years ago this council discussed the desirability of coordinating the various health services in the state government and bringing them under a single jurisdiction to promote better understanding and prevent duplicating efforts. At our second meeting, we reviewed the activities that have taken place in this particular area to include a report of the State Commission of Economy and Efficiency and the introduction of Senate Bill 92, "An Action Relating to the Commission on State Health Services Policy," in the 1966 Kentucky Legislature. We are hopeful that in the near future study will be made of all state agencies providing health services with a result of more efficiency and economy.

Members of this council also discussed the recommendations made and approved by the Board of Trustees of a study made of the KMA council and committee structure. This council is in complete agreement with these changes which are being proposed by the Constitution and Bylaws Committee and feels that this association will be in a position to do a better job for all Kentuckians if these changes are approved.

The report of the committees covering their activities and recommendations follow.

Aging Committee

Earl P. Oliver, M.D., Scottsville, Chairman

Members of the Aging Committee met at KMA Headquarters Office on April 26 to prepare its final report to the 1966 House of Delegates. The meeting was called to order and the duties of the committee reviewed. The report of the Committee on Aging to the 1965 House of Delegates was discussed and commented upon openly.

Doctor Hancock gave a report on the Kentucky Commission on Aging and its current activities. It was noted that the activities of the Commission on Aging had been decreasing in the past year due to lack of support and funds from the present administration. It is recommended that the KMA approach the proper state agency in the administration and stress that more active support be forthcoming for the Commission on Aging as has been received in the past.

The recent activities of the Technical Advisory Committee was discussed and the Committee on Aging voted to endorse the effective work of the Technical Advisory Committee and urge that they continue the program along the lines that have been initiated.

Committee members discussed in great detail PL 89-97 and submitted the following recommendations to the House of Delegates through the Council on Medical Services:

1. The KMA approve and implement item 3 of the Eight Principles affirmed by the AMA House of Delegates at the 1965 Philadelphia meeting: "The physician-patient relationship is served best when there is an advance understanding regarding the payment of fees, and the physician bills the patient directly for services rendered. However, the physician is ethically free to choose in each case the manner in which he is to be compensated, based upon the exercise of his independent judgment."

2. The KMA go on record as supporting and encouraging the accreditation of nursing homes by the JCAH in order to upgrade the facilities for the care of the older citizens. It should be further recommended that the State Board of Health of Kentucky accept accreditation by the JCAH in a category as accreditation in the corresponding category in Kentucky, being mindful that it will be many years before there are enough trained medical personnel to staff the nursing homes in Kentucky.

   That KMA go on record as continuing its support of nursing homes and encourage the future construction of adequate nursing home facilities, but encourage the elimination of luxury items in order to make the cost of care more in proportion to the income of the aged patient.

3. The KMA support and encourage the establishment of a Home Care Program for the senior citizens of Kentucky, and encourage the University of Louisville and University of Kentucky Medical Schools and schools of nursing to train personnel to carry out this program.

4. The KMA insist that the Kentucky Legislature pass legislation which would make the Kentucky Department of Health the administering agency of any Medical Assistance to the Aged Program, rather than joint administration by the Department of Health and the Department of Economic Security, since this is a health program and not a welfare program.

   The KMA also strongly advises and recommends that the Blue Cross and Blue Shield Plans, Inc., Kentucky, or any acceptable, qualified, and approved insurance carrier licensed in the state, be appointed as fiscal intermediary for any Medical Assistance to the Aged Program.

5. The KMA insist on being a partner in the planning and execution of any governmental type of medical program implemented in Kentucky, and not allow a unilateral, bureaucratic, dominated type of program to become a reality.
6. The KMA go on record as encouraging all members to expend every effort to provide the best medical care possible for our older citizens, under conditions which will permit the medical profession to provide this care with honesty, honor, and dignity, and with the least interference by third parties in the physician-patient relationship.

Recommendations, Reference Committee No. 5

With further reference to Report No. 14 in the report of the Aging Committee on Page 3, Reference Committee No. 5 recommends that Paragraph 3 be amended to read "The recent activities of the Technical Advisory Committee were discussed and the Committee on Aging voted to endorse the effective work of the Technical Advisory Committee." On Page 4, Report No. 14, Reference Committee No. 5 recommends that Item #4 be changed to read "The Kentucky Medical Association *strongly urges* that the Kentucky Legislature, etc."

Mr. Speaker, I move the adoption of these amendments. (Motion seconded and carried.)

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Advisory Committee to Blue Cross

George W. Pedigo, M.D., Louisville, Chairman

The Medical Advisory Committee to Blue Cross consists of seventeen appointed doctors from various parts of the state. The first Thursday in each month a meeting of representative members of this committee is held at the Headquarters Office of Blue Cross-Blue Shield in Louisville, Kentucky. At these monthly meetings cases that have been referred by Blue Cross to this committee are reviewed. These are questionable or controversial claims submitted by physicians that deal with the need and duration of hospital care.

The committee is to be congratulated for its diligence, dedication to duty and faithfulness. Their work is not only educational to the other physicians in the state but by accepting the responsibility of this committee's work they indicate that the Kentucky Medical Association and Blue Shield are making an honest effort to screen hospitalization and to keep down unnecessary or prolonged hospital stay by patients.

Annually we have a meeting of the entire commitee in conjunction with representatives from Blue Cross. At this meeting constructive recommendations are made and discussions of the committee's past years work takes place.

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Advisory Commission to Blue Shield

W. Vinson Pierce, M.D., Covington, Chairman

The KMA Advisory Commission to Blue Shield met this year on May 12. We reviewed our report to the House of Delegates last year and were pleased to note it was approved as submitted.

The staff of Blue Shield were guests at our meeting and presented a most gratifying report on Blue Shield activities. As of March 31 of this year, there were over 890,000 Blue Shield members in Kentucky. The constant effort to upgrade the program of Blue Shield members is reflected in the percentage of enrollment increase in 1965 over 1964 during which Extended Benefits coverage increased 31.3 percent and Major Medical 49.2 percent.

In our report to you last year, we brought to your attention the newly initiated concept of prevailing fees in prepayment plans. The experience of the first six months of the prevailing fees program in Jefferson County was reported by the Blue Shield staff to the Advisory Committee. The Advisory Committee notes that the experience has so far equalled and surpassed the expectations of those initiating the program. It feels that this is an approach to the prepayment of medical care which has much to commend it and recommends to the KMA House of Delegates that the Kentucky Blue Shield be encouraged to study and if possible develop a prevailing fee or similar program in those areas of the state that may have an interest in or need for such a program.

With the advent of Medicare and its effective date of July 1, 1966, Blue Cross-Blue Shield had to make adjustments for those people enrolled who were 65 years of age and over. Approximately 31,000 of 43,000 people in this category have transferred, as of early May, to the new "Blue Cross-Blue Shield—65" plan that has been adopted to supplement Medicare.

The following paragraph from the 1965 report of the KMA President to the House of Delegates has been referred to the commission:

> "The KMA has a special committee to assist in making prepayment plans work. I recommend that this committee become more active, especially in the field of over utilization, as well as other irregularities that imperil prepayment plans."

The Advisory Commission considered the above statement and wishes to present this interim report that it is undertaking a study of ways in which to implement this recommendation as well as a continuing search for other new methods to broaden coverage and strengthen the voluntary prepayment system.

Your chairman again wishes to express his appreciation to the members of this commission, the Board of Trustees, and staff of Kentucky Physicians' Mutual, Inc., the KMA House of Delegates and Board of Trustees, and the officers and staff of KMA for their continuing invaluable assistance and support.

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Governmental Medical Services Committee

L. Douglas Atherton, M. D., Louisville, Chairman

To date this committee has met as a whole one time on December 2, 1965. Business was further conducted by a series of informal meetings, correspondence, and telephone calls.

1. *Resolution B* pertaining to VA prescription procedures was inherited from the 1965 House of Delegates September meeting. It was the opinion of the committee that the VA was acting in the spirit of efficiency and economy in encouraging long-term prescriptions be filled by the regional office, and short-term urgent prescriptions be filled by whatever local pharmacy. Doctors offended by this procedure appeared to be very few. A phone call from the chairman to the authors of Resolution B explained the committee's stand.

2. VA Hometown Care Contract for Disabled Veterans was found to arouse no other controversy, and it is anticipated that this contract will be renewed without substantial change.

3. Discussion of the *Medicare Contract for Dependents of the Armed Forces* brought up the problem of revision of fees. There has been no change in fee allowances since adoption of an average prevailing fee for service in 1956. Prior to the December 2 meeting, several independent anesthesiologists requested a change in their fees based on current customary charges. After some correspondence, this

was formally requested in writing by the Kentucky Society of Anesthesiologists. In February, a similar formal request was made by the Louisville E.E.N.T. Society, and in May by the Louisville Obstetrical and Gynecological Society. In April, a letter from Doctor Howard Malony of Covington voiced displeasure with the allowance for obstetrical care.

Two other considerations at the December 2, 1965, meeting led to a broader consideration of fees for service. One was introduced by Doctor Orville Clark, representing several independent anesthesiologists, pointing out a considerable inequity in payment of surgeons fees and anesthesiologists fees for the care of individuals under the aegis of Kentucky Aid for Disabled and Handicapped Children. So far as we knew no KMA committee had any responsibility toward this Kentucky state agency. Our committee was willing to impose upon itself an advisory role in this or any other governmental health agency working with Kentucky physicians. But it strongly felt the necessity of a current prevailing fee schedule for Kentucky doctors before it could recommend any change in fee policy.

The second consideration involved fees and other matters pertaining to implementation of Title XIX of the Social Security Medicare Law. In December 1965, it was not clear which, if any, existing committee of the KMA should undertake this responsibility, and our committee took steps to crystallize the matter.

One thing in common in these three categories of Dependents of Armed Forces Medicare, Title XIX Medicare, and various other governmental medical care contracts was the need for a knowledge of current customary fees of the Kentucky physicians.

On January 5, 1966, your chairman and committee member Doctor Orville Clark, met with officers, advisors, and Blue Shield representative Mr. Avil McKinney to promote direction in this matter. The need for knowledge of prevailing fees was readily admitted. It was decided that getting such knowledge was physically improbable if attempted by the KMA unaided. The responsibility for obtaining this information for use in Title XVIII of the Social Security Medicare was clearly delegated to the Ad Hoc Committee of Doctor Don Chatham. The Blue Shield representative indicated his organization was undertaking to get this knowledge in any event. Therefore, our committee was absolved of this responsibility and seemed destined to await receipt of this information before applying it to its own problems.

The matter of Title XIX of Social Security Medicare was explored. Your chairman and committee member Doctor Paul Parks attended a Chicago AMA information seminar on this subject in January 1966. On February 5, 1966, your chairman, Doctor Orville Clark, and KMA advisors met with Doctor Russell Teague in Frankfort and discussed implementation of Title XIX. It developed that the present KMA advisory committee on Kerr-Mills Legislation, Doctor Waldrop, chairman, was by the nature of its function already doing exactly this, and that plans looking several years ahead were already on paper. In short, the ultimate projection of Kerr-Mills roughly coincided with aims of Title XIX. It was felt, therefore, that responsibility should continue to be with Doctor Waldrop's committee.

The final matter of realistic readjustment of Armed Forces Dependents Medicare fees awaits finality and two possible solutions: (1) Await knowledge of Kentucky doctors' prevailing fee schedule presently being undertaken by Blue Shield and the Ad Hoc Committee of KMA, presumably available later in the year, and request then a general revision of Medicare allowances prior to July 1, 1967, for the year commencing January 1, 1968. (2) Request alteration of allowances for the three specialty groups who have spontaneously given us their current fees, including this alteration alone prior to July 1, 1966, for the contract beginning January 1, 1967.

On May 10, 1966, a letter was dispatched to Colonel Hayes, the responsible government official for Dependents Medicare, asking feasibility of initiating alternative (2) above. No answer as yet.

4. At its December 2, 1965, meeting, the committee proposed that the editors of the KMA Journal publish a series of explanatory articles on various government sponsored programs requiring participation by doctors in the private practice of medicine, to acquaint Kentucky doctors with these programs so that they can more realistically appraise them. The editors then awarded our committee the privilege of writing these articles which, so far, your chairman has not had time or forethought to take advantage of.

5. A letter from Doctor Robert Long requesting information on prenatal care to dependents of soldiers at Fort Knox was referred to a responsible official at Fort Knox and a reply obtained which may have satisfied the inquiry.

Addendum To The Report of The Committee On Governmental Medical Services

At the June 9, 1966, meeting of the committee, it was realized that a prevailing fee schedule of Kentucky physicians was not being prepared by Blue Shield or by any other group to the best of our knowledge. (See item 3, paragraph 7 of committee report.) Therefore, we recommend adoption of the new contract for care of dependents' of armed forces. A request for alteration of allowance for the Kentucky Anesthesiologists group, already presented to us in full with reasons for the change, will be forwarded for negotiation in hopes of including this change as quickly as possible. Requests for alterations and allowances by the Louisville Gynecological-Obstetrical Society and by the Louisville E.E.N.T. Society will also be sent for consideration. However, these latter two groups have been notified that these changes should be recommended by their state specialty groups in order to carry the greatest weight.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 recommends that Item No. 2 be amended to read "VA Hometown Care Contract for Disabled Veterans was reviewed, and it is recommended that renewal of this contract be carried out on the basis of usual and customary fees, rather than a fixed fee schedule."

Mr. Speaker, I move the adoption of this amendment. (Seconded, motion carried).

On Page 10, Report No. 14, Governmental Medical Services Committee Report, Reference Committee No. 5 recommends Paragraph 1 be amended to read "The final matter of realistic readjustment of Armed Forces Dependents Medicare Fees awaits knowledge of Kentucky doctors' fee schedule based on usual and customary charges, with a request to be made for a general revision of Medicare allowances prior to July 1, 1967, for the year commencing January 1, 1968." The addendum to Report No. 14 (from the Committee on Governmental Medical Services) was reviewed by Reference Committee No. 5 and we recommend that this addendum not be accepted, in as much as, under further action by this committee to be shortly reported, it is recommended that a prevailing fee study of Kentucky physicians be carried out shortly.

Mr. Speaker, I move the adoption of these amendments. (Motion seconded and carried.)

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Dependents' Medical Care Review Committee

W. H. Powers, M. D., Louisville, Chairman

There was no called meeting of the Dependents' Medical Care Review Committee in 1966 since there had been no personnel change in this committee and since the committee functions more on an individual, rather than a collective basis. Nevertheless, as individuals, we have reviewed a number of cases in

which there was a questionable allowance for the services provided by the physician. Insofar as possible, the review of each case and the allowance judged to be fair and equitable was made to conform with the manual of medicare allowances. However, in some instances where there were no specific or clear cut allowance made or where the case was rare or extraordinary, an attempt was made to give the doctor attending the patient a fair fee.

During the calendar year of 1965 there were 4,307 claims paid. During the same period a total of $296,408.43 was paid for covered physicians' services. Your Dependents' Medical Care Review Committee reviewed 89 claims during the calendar year 1965. This represents 18 more claims than were reviewed during the 1964 calendar year.

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Insurance Committee

John A. Bishop, M. D., Louisville, Chairman

The Insurance Committee has not met this past year since no matters of any importance were referred to it for action. We sent out letters to all members for matters to be discussed and no one answered, therefore, we assumed no problems existed.

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Mental Health Committee

Logan Gragg, M.D., Lexington, Chairman

The Mental Health Committee met once during the associational year on Thursday, January 13, 1966.

Dale Farabee, M.D., who had recently been appointed Commissioner of the Kentucky Department of Mental Health, had been invited to meet with the committee. He presented a summary of current mental health and mental retardation program developments in Kentucky. He pointed out that certain federal money is available to assist locally supported mental health and mental retardation community programs and that the Department of Mental Health is giving consultation and assistance to communities which are prepared to plan and assist in financing such programs. The involvement of local physicians is essential in these community efforts.

A member of the committee was selected to attend the annual conference of State Mental Health Representatives in Chicago on March 18-19 to participate in exploratory discussions on the possibility of holding a Regional Mental Health Congress involving Kentucky as one of several surrounding states.

The committee members expressed the feeling that a greater proportion of the committee should be non-psychiatric physicians and developed a listing of a number of non-psychiatric physicians with an interest in mental health and mental retardation.

In an effort to provide useful information to county society Mental Health Chairmen the committee directed a copy of the Digest of Proceedings of the January 13 meeting, including Doctor Farabee's report, to each Mental Health Chairman.

The Sub-Committee on Alcoholism was reactivated, with Edward Landis, M.D., as chairman. He reports that although it was not possible for the committee to meet as a whole, considerable time and effort was spent in gathering information which will be useful in the coming year.

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Physicians Placement and Membership Information Committee

George F. McAuliffe, M.D., Chairman, Louisville

This committee did not meet this year, but KMA staff has been extremely busy in carrying out policies previously assigned.

The efforts are directed toward providing a two-way flow of information between interested parties, rather than trying to "place" a physician in the "right" practice situation.

Names of available physicians are obtained from AMA, from lists of interns and residents provided by the individual hospitals in Kentucky and the two medical schools, from the State Selective Service on physicians who will be released from military service, from past Rural Kentucky Medical Scholarship Fund recipients, and from personal inquiries.

This year the need has far exceeded the supply because of the increased requirements of Selective Service. Requests from twenty-five communities and eighty-five physicians requesting associates indicates that we could place over one hundred physicians in Kentucky at this time.

Our Physicians Placement List has carried over 225 names of physicians desiring to locate in Kentucky, although many of these requests have also indicated an interest in other states. A minimum of four mailings of this type are made to interested parties and communities annually. Semi-annually, an "Opportunities for Practice in Kentucky" listing is mailed to interested physicians.

Questionnaires are mailed to all interns, known residents, scholarship recipients, and physicians due to be released from military service. Communities and county medical society secretaries are also mailed survey sheets to keep our information records current.

In addition to the requests coming into our office, we are constantly working to fulfill the needs in the more critical counties of Kentucky.

In the last three years, this committee has recommended twice that the KMA approve the concept of annual registration. An excerpt from our previous reports to you states: "After reviewing the method by which the staff gets its membership information, we find the source to be inadequate. Once a physician gets a license through the Division of Medical Licensure of the State Department of Health in Frankfort to practice in Kentucky, he has no legal obligation to inform the Division, or the Medical Association where he will practice. He can move from county to county, leave the state and return as many times as he wishes and do this without either reporting to the Division of Medical Licensure or to the Headquarters Office. With this method of keeping up with our doctors, we cannot expect our membership department to have accurate records on all practicing physicians in our state."

"Our committee decided that the best solution for this problem would be to have annual registration of physicians and that this be done by the Licensure Division of the State Board of Health. After checking with Russell E. Teague, M.D., Commissioner of Health, we find that his department can require annual registration by regulation instead of by legislation, which will have the effect of law, and this can be done without an annual registration fee.

"Thirty-five states require physicians to register annually, and another ten require registration biennially."

It is our understanding that this matter is being recommended this year by the KMA Committee on Disaster Medical Care, following careful consideration and detailed discussions. This committee would like to take this opportunity to strongly urge the KMA House of Delegates to concur in the recommendation on annual registration being made by the Committee on Disaster Medical Care.

COUNCIL ACTION: It was recommended that the report of the Physicians' Placement and Membership Information Committee be accepted as presented, and the council strongly urges that the House of Delegates approve the recommendation of this committee on annual registration.

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this section of the report with the exception of that portion of the report on Pages 14 and 15 pertaining to Annual Registration which was referred to Reference Committee No. 4. (Motion seconded and carried.)

The committee spent some time soliciting discussion having to do with the proposed registration of all Kentucky physicians, only to discover later that the subject had been referred to another committee for action! It was an interesting discussion however, and it may be of some interest that this committee would have recommended that registration without fee be accepted by this house, had its opinion actually been asked!

COUNCIL ON MEDICAL SERVICES
L. Douglas Atherton, M.D., Louisville
James B. Douglas, M.D., Louisville
Logan Gragg, Jr., M.D., Lexington
Earl P. Oliver, M.D., Scottsville
George W. Pedigo, M.D., Louisville
Claude C. Waldrop, M.D., Williamstown
John A. Bishop, M.D., Jeffersontown, Chairman

Report Of The KMA Technical Advisory Committee On Indigent Medical Care

The KMA Technical Advisory Committee on Indigent Medical Care, in anticipation of a greatly expanded program in July, 1966, met as a group on six different occasions during this associational year. In addition, there were joint meetings held with the Technical Advisory Committee of the Pharmacists and with the Technical Advisory Committee of the Hospitals. There were four meetings of the Kentucky Advisory Council for Medical Assistance. As chairman of the committee. I am particularly grateful to the members for their excellent attendance, personal sacrifice and diligent effort.

At this point, it might be wise to give some historical background on the health and welfare programs and how they have developed through the years. The original program was initiated by the Social Security Act of 1935, which provided basic pension provisions through the employee-employer contribution system, whereby persons reaching retirement age received a monthly pension check. This Act also set up the basic welfare program, which included old age assistance, aid to the blind and aid to dependent children. It also included provisions for child welfare, crippled children and maternal and child health.

In 1960, the Kerr-Mills Program became another category under the original Social Security Act by way of an amendment—the MAA Program. Provisions were made by a special session of the Kentucky General Assembly to participate.

In 1965, there were two major changes in the Social Security Act known as Title XVIII and Title XIX. Title XVIII is commonly known as "Medicare", is for the over 65 age group, and is a federal program. Title XIX concerns itself with grants to states for Medical Assistance Programs. This particular amendment combined Title I—Old Age Assistance and Medical Assistance for the Aged; Title IV—Aid and Services to Needy Families with Children; Title X—Aid to the Blind; Title XIV—Aid to the Permanently and Totally Disabled; and the consolidated program, Title XVI—Aid to the Aged, Blind or Disabled, or for such Aid and Medical Assistance for the Aged.

Title XIX seeks to eliminate this diversity, establishing a single program which makes the same medical care available to all of the states' needy and medically needy. The Act permits various stages of compliance, but by July, 1975, for the state to qualify, it must have an all-inclusive program of assistance in one category, which includes the aged, blind, disabled, and families with children, so that the comprehensive care and services will be available to essentially all medically needy individuals throughout the nation.

The KMA Technical Advisory Committee has consistently presented the views of its organization through the Governor's Advisory Council on Medical Assistance to the state agencies administering the program. However, there have been very few changes from July, 1963 until July, 1966.

During the early part of the associational year, the committee was able to obtain clarification of the letter sent to each physician certifying that they would obey the Title VI of the Civil Rights Act. This original directive was changed so that individual certification by physicians was not necessary.

During the joint meeting with the pharmacists, simplification of the forms and the procedures was discussed. It was recommended that the physician be permitted to use his own prescription blank. Discussion also centered around the maximum quantity of drugs that might be ordered and expansion of the Medical Care Drug List. In July, 1966, modifications in these areas will be implemented for an improved program.

Starting in November, 1965, the committee reaffirmed its stand that it would make continued efforts to see that the compensation to physicians would be commensurate with the fees for other patients, and that beginning now, we would ask for reasonable, customary and current fees for physicians' services. This has been the thinking and philosophy of all the committee members and will continue to be its goal. It has been pointed out to the members of the committee that Title XIX calls for reasonable payments, and that the state finds it very near impossible to pay reasonable and customary charges with a set budgeted amount of money with which to work. State agencies propose that fees be developed on a Relative Value Schedule.

At a meeting of the Technical Advisory Committee, a survey was taken of the five physician members serving in various geographical and population areas of the state. From this, a Relative Value Schedule was developed, based on $5.00 per unit. The plan was presented and approved by the KMA Board of Trustees with the understanding that it would be reviewed at least annually, with the eventual goal being usual and customary fees.

The final meeting of the committee was held approximately ten days prior to the last Governor's Advisory Council meeting, at which time, the July 1st fee schedule was adopted. The committee recommended that an early review should be made in an effort to arrive at usual and reasonable fees in accordance with the advice of the KMA Board of Trustees.

It was also the recommendation of the committee that it concurs with the recommended change inserted by the KMA Board of Trustees under the item "Care of Hospitalized Patients" as follows: " . . . limited to those clinical specialists certified by the appropriate recognized American Specialty Boards or Colleges (and Board Eligible)." Board eligibility should be determined by the physician concerned presenting to the State Board of Health a letter from the specialty board certifying his eligibility for board examination by the full residency requirement method.

This committee has a difficult assignment and is fully cognizant of its responsibility to the physicians and the people of Kentucky. By remaining active in these programs, even though we are not wholehearted-

ly in agreement with their provisions, we must participate and above all try to influence their cources in a direction which would be least destructive to the best interests of the patients.

KMA TECHNICAL ADVISORY COMMITTEE ON INDIGENT MEDICAL CARE
Owen Davis, M.D., Scottsville
George E. Estill, M.D., Maysville
Paul F. Maddox, M.D., Campton
Carroll H. Robie, Jr., M.D., Louisville
C. C. Waldrop, M.D., Williamstown, Chairman

This report was reviewed by the Board of Trustees on August 3, 1966.

BOARD ACTION: Approved with the request that there be an addendum to this report to point out that the advisory committee did not vote to support the principle of usual and customary fees before the Governor's Advisory Council.

Addendum to the Report of the KMA Technical Advisory Committee On Indigent Medical Care

The last meeting of the KMA Technical Advisory Committee on Indigent Medical Care was held on June 3, 1966, with three of five members present. This preceded the June 13 meeting of the Governor's Advisory Council on Medical Assistance when the present Physicians' Fee Schedule was adopted by the council for Kentucky medical assistance patients. At this June 3 meeting, the three members present endorsed the fee schedule presented by representatives of the Kentucky Department of Health which was later approved by the Governor's Advisory Council on June 13.

The Governor's Advisory Council then met again on July 11 to hear testimony relative to this fee schedule. A telephone poll of the KMA Technical Advisory Committee members was made and it was reported to the Governor's Advisory Council at this meeting that the Technical Advisory Committee had voted three to two in favor of the fee schedule as approved by the council at its June 13 meeting.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 recommends the adoption of this report as amended with the comment that it is a historical document and should be read as such. The committee considered this report at some length and feels that it, and the addendum, as amended, are matters of report, and can be accepted as such. With regard to the position of this assembly, it will become clear shortly what the recommendations of this committee are.

On Page 3, Paragraph 2, Reference Committee No. 5 suggests that the sentence beginning "It has been pointed out to the members . . ." be changed to read "It has been pointed out to the members of the committee that Title XIX calls for reasonable payments and that the state found it very near impossible to pay reasonable and customary charges with a set budgeted amount of money with which to work." The following sentence should be amended to read "State agencies proposed that fees be developed on a Relative Value Schedule."

Mr. Speaker, I move the adoption of these amendments. (Motion seconded and carried)

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried)

Report of the Council on Medical Education and Hospitals

Page 6 last paragraph thru first regular paragraph on Page 7

General Practice Committee

The Kentucky Chapter, American Academy of General Practice, Congress of Delegates, in session on May 10, 1966, approved a resolution which in part states as follows:

"RESOLVED, That the Kentucky Chapter of the American Academy of General Practice insist that by July 1, 1966, the needy, as defined in Title 19 of Public Law 89-97, receive at least the same care coverage as the recipients of Title 18 of the same law for the five basic services as well as dental care, drugs, home nursing care, prosthetics, rehabilitative services, physical therapy, and eye glasses. Be it further

RESOLVED, That fees for Physicians be based solely on usual, reasonable, and customary fees for services rendered. Be it further

RESOLVED, That this be presented and supported vigorously to the KMA House of Delegates for its implementation."

This committee recommends to the KMA House of Delegates approval of the above statement by substituting the words "Kentucky Medical Association" for "Kentucky Chapter of the American Academy of General Practice" in the first resolve.

Recommendations, Reference Committee No. 5

The paragraph at the bottom of the page including the resolution extending on to Page 7, with the immediate subsequent paragraph on Page 7, was considered by this committee, and we recommend the adoption of this portion of this report as submitted.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried)

Resolution A
KMA Board of Trustees

WHEREAS, in the United States today there is an increasing trend in private industry to provide paid in full medical care benefits for professional services covered in their fringe benefit programs for employees, and

WHEREAS, Medicine's position, as reaffirmed by the American Medical Association and the Kentucky Medical Association, supports the principle of the payment of professional fees on a usual and customary basis, and

WHEREAS, Title XVIII of PL 89-97 recognizes this principle by defining reasonable charges as those that are customary and prevailing (Page 21 of the HEW Reference Guide for Physicians issued in June 1966), and

WHEREAS, the Commissioner of the Kentucky Department of Health has indicated he supports the usual, customary and prevailing fee concept in the payment of fees under Title XIX, PL 89-97; but to date has felt its use is impracticable in the implementation of Title XIX because of the unpredictability of cost, and

WHEREAS, the Commissioner has further indicated that he felt funds would be forthcoming to provide such a program if predictability were established, and

WHEREAS, the KMA Board of Trustees, in its desire to serve the members of this Association, has devoted long hours in many meetings seeking a method by which physicians would rightfully participate in a survey which would establish usual and customary fees rather than have them non-professionally determined, and which would establish predictability of these fees, and

WHEREAS, the Board of Trustees in its deliberations has recognized the need for skilled experienced staff using highly technical data processing procedures to perform such a survey, and

WHEREAS, at the request of the KMA Board of Trustees, Kentucky Blue Shield with its successful experience in conducting a confidential survey of individual physician's charges, has agreed to do such a survey on a statewide basis in cooperation with KMA and the Kentucky Department of Health,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Kentucky Medical Association endorses the "usual, customary and prevailing" concept and requests the Kentucky Blue Shield to join with KMA and the Kentucky Department of Health in accomplishing a survey of physicians' charges and further that the KMA Board of Trustees implement this endorsement by appointing a special committee made up of representatives from all types of medical practice (with the advice and recommendations of the various medical and surgical specialty groups) to work with Blue Shield and the Department of Health in conducting the survey.

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this resolution as submitted. Motion seconded. After much discussion, it was moved that Resolution A be amended by the insertion at the end of this resolution this sentence: It is understood that information thus obtained will be held in confidence by the KMA Board and Blue Shield as long as desirable. (The motion carried, and the resolution was adopted.)

Irving F. Kanner, M.D., Lexington, President of the Fayette County Medical society, referring to the above adopted resolution, moved to delete the word "prevailing" wherever it appeared and that the word "voluntary" be added in the last paragraph to read "a voluntary survey". (The motion was seconded and carried.)

The Vice-Speaker of the House of Delegates, Richard F. Greathouse, M.D., read the following letter to the members of the House, and requested that it be made a permanent record in the proceedings.

September 20, 1966
George F. Brockman, M.D., Speaker
Kentucky Medical Association
House of Delegates
Dear Doctor Brockman:

The Kentucky Chapter of the American Academy of Pediatrics at its Annual Meeting on September 20 endorsed Resolution A as submitted to the Kentucky Medical Association House of Delegates.

This endorses the proposed survey of usual and customary physicians' fees throughout the state of Kentucky.

Sincerely,

Noble T. Macfarlane, Jr., M.D.
Secretary-Treasurer
Kentucky Chapter American Academy
of Pediatrics
NTM/-

Resolution B
Franklin County Medical Society

WHEREAS, the practice of medicine has been, and is, a relationship between patient and physician, different from commercial ventures, and

WHEREAS, the physician's fee has been one commensurate with the service rendered the patient and

WHEREAS, the payment of the fee by a third party should not interfere with the doctor-patient relationship or the principle of a fair fee for service rendered, and

WHEREAS, "Medicaid" or State sponsored financial aid to the indigent or legally defined medically indigent by establishing fixed fees as payment in full does interfere with the principle of fee for service rendered, therefore

BE IT RESOLVED, 1. that the physician should be able to continue to render a fee commensurate with his service, and 2. that the physician should not be compelled to accept a fixed fee as payment in full.

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this resolution as submitted. (Motion seconded and carried.)

Resolution C
Jefferson County Medical Society

Whereas, it is important and necessary for the medical profession in Kentucky to work closely with the state government in providing medical care under Title XIX of Public Law 89-97, in order that the highest quality of care may be rendered, therefore

Be It Resolved, That the Kentucky Medical Association Legislative Council, with the guidance of the Board of Trustees, be encouraged to start a legislative program authorizing the state to contract with any private agency, business firm, or separate corporation in order to administer the medical care provisions in any or all parts of Title XIX, Public Law 89-97. This contract to administer the program should be executed by the proper state department when in the opinion of the Department of Economic Security and the State Department of Health there would be a sufficient amount of fiscal responsibility built into the agreement as to protect the public interest and still permit medical fees to be paid which are usual, ordinary, and reasonable when compared to all other fees actually paid in the community where a like medical service is being rendered, and

Be It Further Resolved, That the Kentucky Medical Association acknowledges by this resolution its responsibility to assume authority for monitoring the program in order to guarantee it against any medical abuse or over-utilization and that the KMA Board of Trustees be hereby authorized to appoint an ethical and disciplinary committee to work with any private agency, business firm, or corporation to see that the complete needs of the patients are served and at the same time protect the public's interest against fiscal irresponsibility.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 moves the adoption of Resolution C as submitted with the additional comment that discussion in the committee raised the possibility that adoption of a Title XIX program through an intermediary carrier may possibly be even less expensive, in the long run, than direct administration at the state governmental level.

Mr. Speaker, I move the adoption of this resolution as submitted. (Motion seconded and carried)

Resolution G
Fayette County Medical Society

Whereas, the Fayette County Medical Society Resolutions concerning direct billing of patients has been approved by the American Medical Association and by the Board of Trustees of the Kentucky Medical Association (copies of which are attached), and

Whereas, these are now official Kentucky Medical Association policy, and

Whereas, there are contracts now in force between the Kentucky Medical Association and government agencies, including one for the medical care for dependents of service men, which are in conflict with this official policy, therefore be it

Resolved that the Resolutions concerning direct billing which are attached be disseminated in entirety to all members of the Kentucky Medical Association, and be it further

Resolved that all contracts made by the Kentucky Medical Association with government agencies which are in conflict with the present Kentucky Medical Association policy be terminated immediately.

American Medical Association
1966 Annual Meeting

Direct billing has been recommended as the billing method of choice under Title XVIII by the Board of Trustees and the Council on Medical Service. Since there is wide latitude available to individual states in establishing administrative procedures under Title XIX programs, this House of Delegates urges each

constituent state association to work early and diligently, in its own state, to the end that any plan or enabling law developed by the states to qualify as a Title XIX program authorizes such a direct billing procedure and that the Advisory Committee of the American Medical Association to the Department of Health, Education and Welfare be instructed to do all in its power to implement the intent of this resolution at the national level.

Kentucky Medical Association
Board of Trustees

1. That the implementation of Title XIX of Public Law 89-97 be modified in order to continue and to foster our atmosphere of patient-doctor relationship that has been the backbone of American medicine.
2. That the patient be permitted to receive reimbursement for medical services under Title XIX of Public Law 89-97 from the State when a physician chooses to bill the patient directly, and
3. That the usual, customary, and reasonable fees be charged by doctors to patients, and further
4. That a fee schedule of any type imposed by a third party not be accepted by the Kentucky Medical Association, except on an individual basis.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 recommends the following amendments to the last two paragraphs so they may read as follows:

"Resolved that the Resolutions concerning direct billing which are attached be disseminated in entirety to all members of the Kentucky Medical Association, in line with the 'Doctrine of Individual Responsibility' (Report L of the Council on Medical Services Resolutions 9, 10, 32, and 67 of the AMA), and be it further

"Resolved that all contracts made by the Kentucky Medical Association with government agencies which are in conflict with the present Kentucky Medical Association policy be terminated as soon as practicable."

This committee adds the comment that the AMA is working on a legislative program that will allow direct billing to the patient under Title XIX, and supplementary billing to the patient, if governmental funds prove to be insufficient to pay customary fees.

In addition, this committee recommends that the Kentucky Medical Association contact the Department of Health, Education, and Welfare directly and promptly to determine if such a course (i.e. direct billing, utilizing the concept of usual, customary, and reasonable fees), is at present possible under HEW regulations, and if not, requesting adequate explanation concerning this point.

Mr. Speaker, I move the adoption of these amendments. (Motion seconded and carried.)

Mr. Speaker, I move the adoption of this resolution as amended. (Motion seconded and carried.)

Resolution J
Pulaski County Medical Society

Whereas, The American Medical Association has urged its component societies to adopt a program of individual responsibility (Report L of the Council on Medical Service Resolutions 9, 10, 32 and 67); and

Whereas, Quality medical care can only be assured by maintaining the fundamental principles of the patient-physician relationship, free from the influence of third parties; and

Whereas, This tenet is embodied in the Principles of Medical Ethics of the American Medical Association, Section 6, which reads "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of quality of medical care"; and

Whereas, This tenent is embodied in the principles in individual responsibility in which the physician is responsible to the patient for care and for medical services rendered; the patient, in turn, assumes as his personal obligation the responsibility for paying the physician for professional services rendered; and

Whereas, The acceptance of benefits from a fiscal intermediary has posed in the past, and will continue to pose, a distinct threat to the patient-physician relationship which can result in deterioration of quality medical care; and

Whereas, Under the principles of Individual Responsibility, the attending physician's statement is to be regarded as adequate for reports of medical services to patients for reimbursements and services as a "direct billing" mechanism, thus eliminating third party interference in the doctor-patient relationship; therefore be it

Resolved, That the House of Delegates of the Kentucky Medical Association endorses and approves the ethics and the principles of individual responsibility in the rendering of medical services by the physicians, except in the cases where this principle is in conflict with the law of the land; and be it further

Resolved, That the principles of individual responsibility are well sustained by an adequate statement or report by the attending physician, recognized as an ethical means for use by those physicians who voluntarily desire to do so; and be it further

Resolved, That all members of the Kentucky Medical Association be informed of this action so that those physicians who voluntarily wish to do so may employ the principles of individual responsibility in preserving an ethical doctor-patient relationship, and in maintaining the highest quality of medical care.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 recommends that Resolution J not be accepted, because its intent is covered adequately by the amended Resolution G.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Resolution K
Pulaski County Medical Society

Whereas, P. L. 89-97 passed by the 1965 Session of Congress contains many provisions which appear to permit the Department of Health, Education and Welfare to exert unusual interference and control over the manner in which medicine is practiced in this country; and

Whereas, Section 1801 of P. L. 89-97 was written to protect the public, the medical profession and hospitals from such interference and control; and

Whereas, The intent of Congress expressed in the various committee reports is very clear in that such interference and control is prohibited; and

Whereas, Representative Wilbur Mills, Secretary Gardner of HEW, Wilbur Cohen, Arthur Hess and other representatives of this Department have made many public commitments to honor this intent of the Congress; and

Whereas, A strict application of Section 1801 of the Law is the only guarantee medicine has against ultimate total federal control of medical practice which was the basis of medicine's objection to this and other socialized medical laws; and

Whereas, The AMA House of Delegates in Philadelphia, November-December 1965, acknowledged the importance of a strict application of Section 1801 P. L. 89-97; therefore be it

Resolved, That the KMA affirms its policy to insist upon a literal interpretation of Section 1801, Public Law 89-97, in the implementation of this law; and be it further

Resolved, That KMA and county medical associations alert their individual members to the possibility of violation of this Section of the Act and provide a mechanism by which such violations can be reported factually and completely to the American Medical Association.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 recommends the adoption of this resolution as submitted.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Resolution L
Pulaski County Medical Society

Whereas, many segments of medicine have endorsed the policy that physicians bill their patients directly under Public Law 89-97, rather than accepting assignments and billing the agent; and

Whereas, Kentucky has implemented Title XIX in part, by expansion of Kerr-Mills benefits; therefore be it

Resolved, That the Kentucky Medical Association use all possible influence to secure the same right in the expansion of Kerr-Mills and implementation of Title XIX, i.e., the right to bill their own patients who in turn shall secure reimbursement from the state or its agents; and be it further

Resolved, That when the physician elects not to receive an assignment, he and his patient alone shall determine the amount of the bill and the state may set the fee only when the physician accepts an assignment.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 recommends that this resolution not be adopted because it is adequately covered in Resolutions B and G preceding.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried)

Report of the Board of Directors of Kentucky Physicians Mutual, Inc.

In this our seventeenth year of operation, it is my privilege, as chairman of the Board of Directors of Kentucky Physicians Mutual, to present for my second (and final) time the Annual Report of the Board to you, the House of Delegates of the Kentucky Medical Association.

This report is certainly one of increasing progress. As of June 30, 1966, 889,915 people were members of the plan, this number representing an increase of 14,984 over the previous year. There have been increased enrollments in both the Extended Benefits Program of over 10,378 and in Major Medical of 1,418. A total of approximately $12,000,000 will have been paid to the physicians of Kentucky in the calendar year 1966—or approximately $5,400 per physician. The cost of operation has likewise been the source of satisfaction in that Kentucky Physicians Mutual has had an operational cost which has been matched or bettered by only 7 of the 74 Blue Shield Plans in the country.

In the year since this report was last presented, the "Prevailing Fees" concept, which received its start and greatest impetus from Kentucky, has proven successful in the experimental group, and Jefferson County Medical Society has agreed to extend it to still another group in this area. This concept is well worth consideration by all of your respective medical constituencies as more and more labor-management groups are interested in exploring its possibilities in future negotiations; and certainly the Medical Profession should be in a position of intelligently understanding its potentialities. We would like to extend to you the services of our staff in explaining to your groups the concept of "Prevailing Fees" whenever you are interested in having it presented for your considered judgment.

So, gentlemen (and ladies) in the past year your Blue Shield Plan, i.e. Kentucky Physicians Mutual, has proven itself progressive, initiative, financially sound, and respected in the nation. So ends the glorious (and pleasant) portion of the report.

As you know, in the past year the Kentucky Medical Association through the agency of its Board of Trustees, requested Blue Shield to administer Part B of the Medicare program. Despite many misgivings in the minds of the members of the Board, but, as always, willing to do the bidding of the Medical Profession in as far as possible, it was agreed and an application was submitted to the Department of Health, Education, and Welfare. Shortly before the date for Medicare to begin, HEW informed us that the services of Blue Shield were not needed in Kentucky, and that an insurance company would perform this function. The Board and staff were, needless to say, personally relieved because it was fully realized that restrictive governmental regulations in this situation would have jeopardized the previous pleasant relationship between the medical profession and Blue Shield. Now we could continue to work and perform and render service to the majority of the people of Kentucky and to the Medical Profession without worries of unavoidable embarrassment.

So we thought————

Shortly before Medicare took over on July 1, letters, personal inquiries, telephone calls began to pour into the office. Why has Blue Shield (and Blue Cross) sold the people and the Medical Profession down the road? Why cannot people who are not socialistic, who believe in free enterprise and personal responsibilities, financial as well as moral, just because of age, be deprived of their rights to share their risks through the long established custom of underwriting through insurance companies or Blue Cross and Blue Shield? Must we, they asked, become wards of the Government will or no? Look about your Board of Directors Table, we were charged, and see the Machiavellis, the Rasputins, the Quislings, the Arnolds!

As chairman of the Board, I looked about the table————

I saw, not Nicholo Machiavelli—but Everett Baker
Not Georgi Rasputin—but only Bill Massie
Not Vidking Quisling—only Garnett Sweeney
Not Benedict Arnold—but Delmas Clardy

From chair to chair I observed the faces—and I saw only men who have been more vociferous in anti-socialistic activities than most of you here present; men who have spent much of their time and energy in promoting what we have long considered a philosophy of life, i.e., free enterprise. But these men are doctors—trained in a rigid discipline that states, among other things, that if you are unable to help your patient, you can certainly be no party to hurting him.

As a Board, these men are not able to alter the laws and philosphy of the Government; namely that people over age 65 (regardless of their wealth) are unable to provide, by themselves, for their own medical care. In order to provide this care, the Medicare program has been instituted whereby, under Social Security taxes, the younger, productive people of the country are taxed to pay for this, and, under the present rate, with a maximum yearly income, this amounts to about $106.00 per taxpayer. In the past year, under the present Blue Shield (over 65) Plans, a total loss of $68,000 was sustained. This loss, according to sound insurance principles, had to be pro-rated over the less vulnerable group, namely, those under 65, in order for the Plan to remain solvent. To allow this continuing loss among our younger subscribers in addition to their being forced to contribute to Social Security taxes in order to sustain Medicare, would render them in double jeopardy financially. This is decidedly unfair, and

cannot be justified under any sound principle of equity. Therefore, the best we could offer was to supplement the law as it exists in order to provide for the people over 65, with services comparable to what they had prior to the enforced governmental plan at a reasonable dues. To this we stand committed. We respectfully await your considered judgement.

The thanks of the Board is extended to the members of the Medical Profession who by their cooperation, have made another successful year for Blue Shield. I would like to add my personal thanks to the Board Members, fellow officers, and the Staff for their efforts in these trying times.

Richard J. Rust, M.D., President
Kentucky Physicians Mutual

Recommendations, Reference Committee No. 5

On Page 3 the reference committee was pleased, in the midst of a lengthy and basically serious afternoon, to encounter Doctor Rust's epic comparison as he looked about the table of his Board of Trustees. We were pleased with his literary style, but this did not prevent considerable discussion arising concerning the "Over 65 Blue Shield Plan". This committee recommends the adoption of this report as submitted, with the reservation that considerable comment ensued about several aspects of the plan. This committee recommends the adoption of the report as submitted, and adds the following observations:

a. That no other Blue Shield coverage is available to this age range

b. that the coverage which is available under this plan is somewhat limited

c. that there is evident need for better explanation to patients of the limitations of such coverage.

This committee recommends that consideration be given by the Board of Trustees of Kentucky Physicians' Mutual to studies which may lead to the possibility of more effective coverage for patients in this age range, as a supplement to the Medicare Law.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the Council on Allied Professions and Related Groups

Page 2, second paragraph thru top of Page 3, Board action and addendum, Tuberculosis Committee

In addition to the final report submitted by the Tuberculosis Committee to the council, Richard Mardis, M.D., appeared in person to submit an addendum, acting for the committee chairman, Joseph Humpert, M.D., who was out of the state. He submitted reference material to support the request of the committee that this council recommend through channels that the detection and treatment of tuberculosis in the commonwealth be unified under one authority, namely the Kentucky Tuberculosis Hospital Commission. After due consideration of the following:

1. Since universal school testing, subject to the approval of the local county medical society, was advised by the Kentucky Medical Association in 1964 in grades one through twelve has not been instituted;

2. Since 85 percent of the cases detected are graded as moderate or far advanced;

3. Since the number of new cases reported annually has remained static since 1959 suggesting no improvement in treatment during this period;

4. Since the TB Committee of the KMA agrees unanimously that emphasis should be placed on tuberculin testing of the school population, grades one through twelve, followed by chest survey of all positive reactors and their immediate contacts: and

5. Since according to the statement of Stuart Lauder, M.D., Director of TB Control of the Health Department, a current register of TB cases was non-existent in 49 counties (41 percent), the council has voted to endorse the recommendation of the TB Committee and recommends endorsement through channels that the detection and treatment of tuberculosis in the commonwealth be unified under one authority, namely the Kentucky Tuberculosis Hospital Commission.

This report was reviewed by the Board of Trustees on August 4, 1966.

BOARD ACTION: Approved with the following exceptions: The Board disapproves the recommendations of the TB Committee endorsed by the Council on Page 3 that the detection and treatment of tuberculosis should be transferred to and under the authority of the Kentucky Tuberculosis Hospital Commission. The Board feels that detection and treatment should be under one authority, but that this authority should be the State Department of Health. The Board approves the remainder of the report with the recommendation, however, that the incidence of TB testing in the schools and the x-raying of elderly people be determined by the Department of Health.

Addendum To Final Report Of The Tuberculosis Committee

The Tuberculosis Committee wishes to present this addendum to our final report: "The Tuberculosis Committee has always felt that a well coordinated attack on Tuberculosis is needed in Kentucky. The Kentucky Medical Association was always active in the Coordinating Council for the Control of Tuberculosis when the body was active. After that Council ceased to function, the Tuberculosis Committee recommended to the Tuberculosis Control Officer of the State Health Department three years ago, that the Council should be reactivated. The Council has not been reactivated. On the contrary the program of tuberculosis detection, follow up and control in the state has lagged and has suffered from lack of dynamic leadership.

Recently cooperation between the various state agencies in tuberculosis work reached a nadir, when a directive from the Division of Tuberculosis Control of the State Health Department to all County Health Departments suggested that the local health departments not cooperate with the State Tuberculosis Hospital Commissions' representatives in the tuberculosis testing programs in schools.

In contrast to the slow progress being made in tuberculosis detection, follow up and control, the State Tuberculosis Hospital Commission has made an outstanding and enviable record in the treatment of tuberculosis.

The Tuberculosis Committee therefore reiterates the recommendation made three years ago that the entire program of detection, control, and treatment of tuberculosis in Kentucky should be coordinated under one group, organization, or agency. Of the two state agencies involved, the Tuberculosis Committee recommends that the one best able to lead this program would be the State Tuberculosis Hospital Commission. The Tuberculosis Committee wishes that the Board of Trustees of the House of Delegates approve this recommendation and pass it on to the Governor of the State."

Recommendations, Reference Committee No. 5

This committee considered the Tuberculosis Committee report, starting at the second paragraph on Page 2 of Report No. 16 terminating with the small paragraph at the top of Page 3. In addition, we considered the Board action at the bottom of Page 43 and the addendum to the final report of the Tuberculosis Committee found at the back of the report. Reference Committee No. 5 concurs with the Board action on this report, finding nothing in the addendum which would change the recommendation, and recommends that this particular portion of this Council's report not be accepted.

Mr. Speaker, I move the adoption of this section of the Reference Committee No. 5 report. Motion seconded. Thomas L. Heavern, Jr., M.D., Newport, of the Campbell-Kenton County Medical Society, moved to amend the Approved Board Action by inserting after the words "that the incidence of TB testing in the schools" the statement that "such testing to be undertaken only with the advice and consent of the county medical society in the county in which a school is located." (This amendment was seconded and the motion carried.)

Report of the Advisory Committee to Selective Service

The KMA Advisory Committee to Selective Service has held four meetings since September 1965 with top officials of the State Headquarters for Selective Service. The purpose of this committee, which is quasi-governmental, is to try to maintain an appropriate balance and distribution of medical care for our people, as well as the armed forces.

This committee reviews cases and makes recommendations to the State Selective Service who in turn can then recommend to a local draft board. Since 1961, the quota has been filled with interns, but with the escalation of the war in Viet Nam the call this year included any physician 35 years of age or under who had not completed his military obligation. In this classification, Kentucky had approximately 160 physicians under the age of 35.

The order of selection began at the age of 26 in the order of birth dates, with the youngest selected first. The national call was for 2,496 physicians. Since it was not the intention of the Selective Service to wreck a hospital, college board, or a community, the recommendation has been made that some physicians be reclassified as "2A", which is an occupational deferment. The Advisory Committee has carefully reviewed each applicant referred to it and has applied the policy of adhering to the regulations issued by Selective Service Headquarters in Washington.

We have had excellent cooperation on the part of Col. Everett Stephenson and Col. Marshall Sanders and are indebted to the KMA Headquarters Staff for much basic information required by the committee. Your committee has been most conscientious and if any mistakes were made, this is most regrettable.

Your chairman attended an AMA meeting on National Selective Service held in Chicago on June 27, 1966, which confirms that the action of advisory groups in other states were consistent with our program.

ADVISORY COMMITTEE TO SELECTIVE SERVICE
J. Duffy Hancock, M.D., Louisville, Chairman
Glenn U. Dorroh, M.D., Lexington, Vice-Chairman
James Archer, M.D., Paintsville (Deceased)
Charles B. Billington, M.D., Paducah
Sydney G. Dyer, M.D., LaCenter
Sam A. Overstreet, M.D., Louisville
Marcus G. Randall, D.D.S., Louisville
L. S. Shirrell, D.V.M., Frankfort
Russell E. Teague, M.D., Frankfort
L. O. Toomey, M.D., Bowling Green
Miss Celestia Uftring, R.N., Louisville

Recommendations, Reference Committee No. 5

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the Rural Kentucky Medical Scholarship Fund

The Fund is pleased to report that a total of 35 new and renewal loans were approved for an appropriation of $60,200. The Fund, in approving these loans now has a record of having helped a total of 282 students. Scholarship recipients are now located in 80 of the 120 counties in Kentucky.

The KMA staff processes all loans and contracts and does the record keeping for the Rural Kentucky Medical Scholarship Fund. A quarterly financial report is submitted to the Board of Trustees of the Fund, which now has over $450,000 on loan. Progress reports are secured on students in medical school, and contact is maintained with interns, recipients in the armed services, those in specialty training and past recipients in practice.

There are two scholarship programs offered by the Fund. One plan stipulates that a recipient may make a loan up to $1,300 per year at the rate of 2% to maturity, when the rate increases to 6%, if he practices in a rural section acceptable to the Fund for each year he secures a loan.

Under the second plan, a student may borrow up to $2,000 a year providing he contracts to practice in a county designated as having a critical shortage of physicians. One year's loan will be waived for each year that he practices in one of these counties.

To encourage physicians to locate in the more needed areas, two types of loans with forgiveness features are now available through the Fund. Under the first arrangement, to any physician who will establish a practice in one of the ten most critical counties, the Fund will lend $2,000 and waive $500 per year for each year of practice in this location. The ten critical counties for 1966-67 are: Carter, Martin, Knott, Crittenden, Metcalfe, Powell, Lewis, Wolfe, Rockcastle and Magoffin.

The second plan, featured for the first time this year, designates the next ten counties where there is a critical shortage as "semi-critical" counties. This new phase permits a physician to borrow $1,000 to set up a practice with $250 per year forgiven. Semi-critical counties are: Leslie, Owsley, Jackson, Butler, Breathitt, Lincoln, Meade, Owen, Clay and Estill.

The twenty counties are selected on the basis of information supplied by the Kentucky Medical Association and the Kentucky State Board of Health. Although the critical county program is relatively new, the results have been most encouraging. There are now eight physicians in practice in these areas, and eight medical students who have agreed to locate where the need is most vital.

The Fund constantly keeps in mind the need for physicians in all the rural areas of Kentucky and has now supplied physicians to over three-fourths of the counties in the state. We now have 122 physicians in active practice and 103 scholarship recipients who are either in medical school, in the service or now completing their training, who have agreed to practice in rural areas other than the ten critical counties.

The Board of Trustees is especially appreciative of the continued interest and support of Governor Edward T. Breathitt, Health Commissioner Russell E. Teague, M.D., and the Kentucky General Assembly.

The Chairman of the Fund was very grateful for the special tribute that was presented by the Vice-Chairman at the May 18 meeting, commemorating the 20th Anniversary of the Rural Kentucky Medical Scholarship Fund.

RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND
C. C. Howard, M.D., Glasgow
Chairman, Board of Trustees

Recommendations, Reference Committee No. 5

Reference Committee No. 5 approves this report as submitted with the comment that discussion in the committee brought out the fact that this appears to be a most valuable program, well worth future encouragement and report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 5 as a whole, as amended. (Motion seconded and carried.)

I should like personally to thank the members of this committee for quite cheerful and interested support and help throughout, Doctors Johnson, Ferrell, Moore, and Wyatt, and once again thank those of you kind enough to help us by bringing pertinent information and opinions before the committee Monday afternoon.

REFERENCE COMMITTEE NO. 5
James L. Ferrell, M.D., Paris
Robert T. Johnson, M.D., Beaver Dam
Andrew M. Moore, M.D., Lexington
William Wyatt, M.D., Somerset
Walter I. Hume, Jr., M.D., Louisville, Chairman

REFERENCE COMMITTEE NO. 6†

W. Vinson Pierce, M.D., Chairman

Reports on Constitution and Bylaws; Special Committees

See Note (†) bottom of column one, page 1122.

Reference Committee No. 6 considered the following reports:

17. Advisory Committee to the Editor
18. Judicial Council
19. Committee on Third Party Medicine
20. Committee to Study the Constitution and Bylaws
21. Interim Meeting Program Committee
22. Insurance Review Board

This Reference Committee also considered a portion of Report No. 14, Report of the Council on Medical Services, paragraph 3, page 2; and Report No. 16, Report of the Council on Allied Professions and Related Groups, page 14, paragraph 2.

Report of the Advisory Committee to the Editor

During the 1965-66 associational year, your committee held no meetings with the editors.

The business of The Journal has been extremely smooth and satisfactory this year. There have been no problems which the Editors, the staff, or the committee felt were necessary to consider or to require any action by the committee.

Your committee chairman attended a meeting in Chicago by the State Medical Journal Advertising Bureau and learned a good deal about the handling of the advertising for the various state journals. There has been marked improvement in the amount of advertising The Journal receives. The foremat of The Journal has continued as in the previous year with one change in the cover, deleting the word "state" from Kentucky Medical Association.

The committee members express their appreciation to the Editors for the splendid service they are rendering the profession as a result of their work on The Journal.

ADVISORY COMMITTEE TO THE EDITORS
Patrick J. Murphy, M.D., Lebanon Junction
Robert G. Overstreet, M.D., Louisville
Eugene Q. Parr, M.D., Lexington
Gerald B. Reams, M.D., Ashland
Orson P. Smith, M.D., Louisville
Frederick A. Scott, M.D., Madisonville
Blaine Lewis, Jr., M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

During the past year, the business of The Journal has been so well managed that no problems arose which required action by the Advisory Committee. The Chairman of the Committee, Blaine Lewis, Jr., M.D., attended a meeting in Chicago of the State Medical Journal Advertising Bureau. It is encouraging to note that the amount of advertising received by The Journal this past year has increased.

Mr. Speaker, I move the acceptance of this portion of the report. (The motion was seconded and carried.)

Report of the Judicial Council

The Judicial Council has just completed its first full year since the adoption of rules and regulations for processing grievances and matters involving ethics. It had five meetings in the past Associational year, during which it considered ten complaints and ten requests for opinions on the ethics of various practices. Under the rules of the Council, its records relative to grievances and complaints are confidential and not accessible to anyone other than the members of the Council, its staff, the parties involved and their counsel, if any. For this reason, it would be improper to include in this report any details of specific cases.

However, it is appropriate for the Council to inform you that, according to our records, only 21 county societies have grievance committees. Much needs to be done at the local level in this regard.

Your council has also been deeply concerned about the current difficulty in which specialists in radiology and pathology find themselves. We were asked by both specialty groups to enunciate the ethical guidelines within which they should pattern their relationship with hospitals. We adopted the following five statements of legal and ethical principles applicable to the practice of medicine in hospitals:

"1. The practice of pathology and the practice of radiology are no less the practice of medicine because carried on in a hospital.

"2. The practice of medicine includes the services of technicians performed under the supervision and direction of licensed physicians, at least to the extent that those services would constitute the unlicensed practice of medicine if *not* performed as the agent of a licensed physician, and to the extent that the supervising physician is legally responsible to the patient or the hospital for the quality of such technical services.

"3. A hospital cannot be licensed to practice medicine and therefore cannot provide medical services to patients through and by means of employed licensed physicians, or technicians whose services are performed as the agents of licensed physicians.

"4. If a hospital cannot provide medical services to patients, it would seem to follow that it cannot collect a fee for medical services from patients, unless it does so as a clearly identified collecting agent for the physicians who provided those services.

"5. Any physician who is a party to any arrangement under which a hospital is permitted to purvey his services or those of technical personnel who are his legal agents, to patients, is therefore not only guilty of unethical practice but is liable to revocation of his license for aiding and abetting the unlicensed practice of medicine."

We have withheld enforcement of those rules out of deference to the current state of confusion within the two specialties most intimately involved. When the air has cleared to the point that the Council is of the opinion that physicians who are not in compliance with the foregoing principles should be disciplined, the membership will be so advised through appropriate channels of communication.

KMA JUDICIAL COUNCIL
Henry B. Asman, M.D., Louisville
J. Duffy Hancock, M.D., Louisville
Hugh L. Houston, M.D., Murray
Clyde C. Sparks, M.D., Ashland
N. L. Bosworth, M.D., Lexington, Chairman

Recommendations, Reference Committee No. 6

The Judicial Council in completing its first full year under the new rules and regulations held five meetings in which it considered ten complaints and ten requests for opinions on ethics.

The Council report called attention to the fact that only 21 county societies are on record as having grievance committees. Much needs to be done in the local level in this regard.

The Council has been deeply concerned about the current difficulty in which specialists in radiology and pathology find themselves. The Committee is also aware that other physicians may encounter similar difficulties in the practice of medicine. The Judicial Council proposed the following five statements of legal and ethical principles regarding the practice of medicine in hospitals:

"1. The practice of pathology and the practice of radiology are no less the practice of medicine because carried on in a hospital.

"2. The practice of medicine includes the services of technicians performed under the supervision and direction of licensed physicians, at least to the extent that those services would constitute the unlicensed practice of medicine if *not* performed as the agent of a licensed physician, and to the extent that the supervising physician is legally responsible to the patient or the hospital for the quality of such technical services.

"3. A hospital cannot be licensed to practice medicine and therefore cannot provide medical services to patients through and by means of employed licensed physicians, or technicians whose services are performed as the agents of licensed physicians.

"4. If a hospital cannot provide medical services to patients, it would seem to follow that it cannot collect a fee for medical services from patients, unless it does so as a clearly identified collecting agent for the physicians who provided those services.

"5. Any physician who is a party to any arrangement under which a hospital is permitted to purvey his services or those of technical personnel who are his legal agents, to patients, is therefore not only guilty of unethical practice but is liable to revocation of his license for aiding and abetting the unlicensed practice of medicine."

The Judicial Council does not feel that enforcement of these rules is applicable at this time, but is of the opinion that when the air has sufficiently cleared physicians who are not in compliance with the foregoing principles should be disciplined. Your Reference Committee wishes to point out that the most important aspect is to recognize that certain services performed in the hospital are the practice of medicine and these services should be clearly delineated.

Mr. Speaker, I move the adoption of this portion of the report. (Motion seconded; carried.)

Report of the Committee On Third Party Medicine

Problems in regard to Third Party Medicine have not been presented or referred to this Committee since the last session of the House of Delegates. For this reason, the Third Party Committee did not have a meeting.

COMMITTEE ON THIRD PARTY MEDICINE
Walter L. Boswell, M.D., Lexington
Ballard W. Cassady, M.D., Pikeville
Robert B. Jasper, M.D., Somerset
Robert E. Norsworthy, M.D., Hartford
John S. Harter, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

The Committee on Third Party Medicine did not meet since no problems have been referred to it during the past year.

Mr. Speaker, I move the adoption of this portion of the report. (The motion was seconded; carried.)

Report of the Constitution and Bylaws Committee

The Committee to Study the Constitution and Bylaws held an afternoon meeting on June 2. Mr. E. Gaines Davis, KMA Legal Counsel, was in attendance.

A discussion was held on a number of matters relative to making changes, additions, and deletions to our Bylaws. Your committee is of the opinion that there are changes needed in the following four areas:

1. All committees, including those appointed as Ad Hoc Committees, should be terminated simultaneous with the appointing authority. This means that no such committee is appointed for a term of office for more than one year although it can be reappointed by the incoming Board of Trustees. This will eliminate the continuance of committees that are no longer essential to the association's activities.

2. No committee should consist of more than seven members unless given specific approval by the Board of Trustees. Some committees have become unnecessarily burdened in size and have difficulty in securing a quorum for their meetings.

3. Your association often finds itself in a position of being asked by the House of Delegates to conduct programs requiring substantial financing when such expenditures have not been budgeted and no means for financing such programs have been presented. This works a hardship on the budget since funds must be available from some source within the budget. Your committee feels it to be in the best interest of all concerned that the House of Delegates not authorize any program for which no funds are known to be available without recommending a source for securing such funds.

4. Our major item for your consideration this year has resulted from a study of the KMA Committee and Council Structure requested by the Board of Trustees from an Ad Hoc Committee consisting of: George Brockman, M.D., Greenville, Chairman; W. Vinson Pierce, M.D., Covington; and Wyatt Norvell, M.D., New Castle.

This study represents the desire of your Board of Trustees to continue its leadership in vigorously promoting the betterment of the Association, planning for the future, and coping with the rapid expansion of governmental health programs. This is the first major change in our present organizational structure, and initiates a continuing program of close scruntiny of the Association's organizational structure, policies, projects, and related activities to provide the membership with the best possible service.

Upon completion of their study, the committee members recommended a revised committee and council structure, eliminating some committees and combining their duties with other committees or councils, elimination of one council and addition of a Council on Governmental Medical Services and other similar changes. The recommendations of the Ad Hoc Committee have been approved by the Board of Trustees and your Bylaws Committee has been asked to submit proposed changes in our Bylaws to implement these changes in our organizational structure.

The above recommendations will be implemented upon House of Delegates approval of the following proposed Bylaw changes:

CHAPTER VIII. Standing Committees and Councils.

Present Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of four standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws.
(b) A Committee on Third Party Medicine.
(c) A Committee on Arrangements for the Interim Meeting.
(d) An Advisory Committee to the Editor of the Journal.

Proposed Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairman of six standing committees composed of not less than five nor more than seven members, as follows:
(a) A Committee to Study the Constitution and Bylaws.
(b) A Committee on Arrangements for the Interim Meeting.
(c) An Advisory Committee to the Editor of the Journal.
(d) A Board of Managers of the McDowell House.
(e) An Insurance Review Board.
(f) A Memorials Commission.

Present Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:
(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Allied Professions and Related Groups.

Proposed Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairman of six Councils, composed of not less than five nor more than seven members, as follows:
(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Governmental Medical Services.

Section 3. No change proposed.

Section 4. No change proposed.

Section 5. No change proposed.

Present Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. Such committees shall serve at the pleasure of the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Proposed Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. No committee shall be composed of more than seven members unless specifically so provided by the Board. All such committees shall expire at the end of the Associational year unless earlier dissolved by the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. No change proposed.

Section 8. Delete entire present section, which pertains to the Committee on Third Party Medicine.

Proposed Section 8. The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committees for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Proposed Section 9. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Proposed Section 10. The Insurance Review Board shall provide a forum in which disputes between physicians, their patient-insureds, and insurance carriers can be mediated.

Proposed Section 11. The Board of Managers of the McDowell House shall be responsible for the proper maintenance and operation of the McDowell House and Apothecary Shop under the general guidance of the Board of Trustees.

Proposed Section 12. The Memorials Commission shall endeavor to finance the furnishing of the Board Room and the Presidents Office, may accept memorial contributions to the Association and collect books, medical instruments and other memorabilia associated with the early practice of medicine for inclusion in the display on exhibition in the President's Office.

Proposed Section 13. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Proposed Section (14). The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Association Education Research Foundation, and concerning itself with problems relating to nongovernmental medical and hospital care, general practice, research and such other matters in this general field as may be referred to it by the Board.

Proposed Section 15. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its considera-

tion. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Proposed Section 16. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc. and Blue Cross plans. It shall serve as a clearing house on all non-governmental fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care to all segments of the population through physician placement and other means.

Proposed Section 17. The Council on Communications and Public Service shall supervise and direct all Associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, highway safety, disaster medical care and diabetes. In addition, it shall assist the Board in presenting the Orientation Course referred to in Chapter I, Section 5.

Proposed Section 18. The Council on Governmental Medical Services shall concern itself with all programs of medical care offered by governmental agencies, maintaining close liaison with the State Department of Health and other governmental units involved with such programs. It shall keep the Board of Trustees informed of all innovations in the field of governmental medicine and advise the Board as to any action which the Association should take with regard to such programs.

COMMITTEE TO STUDY THE CONSTITUTION AND BYLAWS
John S. Baughman, III, M.D., Harrodsburg
Matthew C. Darnell, Jr., M.D., Lexington
W. Bruce Hamilton, M.D., Shepherdsville
James G. Sills, M.D., Hardinsburg
William B. Stodghill, M.D., Louisville
Douglas H. Jenkins, M.D., Richmond,
Chairman

Addendum To The Report Of The Committee to Study The Constitution and Bylaws

Present Chapter IX, Section 3 of the Bylaws:

"All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective".

Proposed Chapter IX, Section 3 of the Bylaws:

"All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution."

Recommendations, Reference Committee No. 6

The Constitution and Bylaws Committee is of the opinion that changes are needed in four areas in our present Constitution and Bylaws.

1. All committees should be terminated simultaneous with the appointing authority. This means that no committee is appointed for a term of office of more than one year, unless the Bylaws otherwise specifically provide. The outgoing committee can be reappointed by the incoming Board of Trustees at its discretion. This will eliminate the continuance of committees that are no longer essential to the Association's activities.

2. No committee should consist of more than seven members unless given specific approval by the Board of Trustees.

3. The Association often finds itself in a position of being asked by the House of Delegates to conduct programs requiring substantial financing when such expenditures have not been budgeted and no means for financing such programs have been presented. This works a hardship on the budget. The Committee feels that the House of Delegates should not authorize any program for which no funds are known to be available without recommending a source for securing such funds and recommends present Chapter IX, Section 3 to be changed as follows:

"All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution."

Mr. Speaker, I move the adoption of this portion of the report. (Motion seconded and carried.)

4. Earlier this year the Board of Trustees appointed an Ad Hoc Committee consisting of George F. Brockman, M.D., W. Vinson Pierce, M.D., and Wyatt Norvell, M.D., to make a study of the KMA committee and council structure. This study represents the desire of the Board of Trustees to continue its leadership in promoting the betterment of the Association, planning for the future, and coping with the rapid expansion of governmental health programs. This is part of a continuing program of close scrutiny of the Association's structure, policies, projects and activities.

Several recommendations of the Ad Hoc Committee which were studied by the Constitution and Bylaws Committee are incorporated in the following changes, which we feel should be specifically pointed out in order to permit House action regarding these recommendations. If approved by the House of Delegates, the suggested changes will then be effective.

Chapter VIII. Standing Committees and Councils. Section 1, the proposed Section 1 reads as follows:

"The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of six standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws.
(b) A Committee on Arrangements for the Interim Meeting.
(c) An Advisory Committee to the Editor of the Journal.
(d) A Board of Managers of the McDowell House.
(e) An Insurance Review Board.
(f) A Memorials Commission."

Comment: The last three of these are newly created committees of the House. The Reference Committee suggests the following amendment to the wording of the proposed Section 1, towit instead of saying "the chairmen of six standing committees" this should read "the chairmen of six standing committees and or boards or commissions".

Mr. Speaker, I move the adoption of the amendment. (Motion seconded; carried.)

Mr. Speaker, I move the deletion of present Section 1 and the adoption of proposed Section 1 as amended. (The motion was seconded and carried.)

Proposed Section 2:

"The Board of Trustees shall, in the same manner,

(except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven menbers, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Governmental Medical Services.

Your Reference Committee wishes to call attention to the fact that one Council has been dropped from the present Section 2, viz, the Council on Allied Professions and Related Groups. The Reference Committee also calls your attention to the fact that a new Council, the Council on Governmental Medical Services, has been created by this proposed change.

The Reference Committee feels that in dropping the Council on Allied Professions and Related Groups some provision should be made for the functions previously performed by said Council and recommends that the Board of Trustees properly assign these functions among appropriate other Councils.

Mr. Speaker, I move the deletion of present Section 2 and the adoption of proposed Section 2. (Motion seconded and carried.)

Section 3. No change proposed.

Section 4. No change proposed.

Section 5. No change proposed.

Proposed Section 6:

"The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. *No committee shall be composed of more than seven members unless specifically so provided by the Board. All such committees shall expire at the end of the Associational year unless earlier dissolved by the Board.*

"In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine."

Mr. Speaker, I move the deletion of present Section 6 and the adoption of proposed Section 6. (The motion was seconded and carried.)

Section 7. No change proposed.

Section 8. The Committee on Constitution and Bylaws recommends deletion of the present entire Section 8, which pertains to the Committee on Third Party Medicine.

Mr. Speaker, I move the adoption of this recommendation. (Motion seconded; carried.)

Proposed Section 8:

"The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference."

Mr. Speaker, I move the adoption of proposed Section 8. (Motion was seconded and carried.)

Proposed Section 9 is in the present Constitution and Bylaws as Section 10 and no change has been made other than changing it to Section 9.

Mr. Speaker, I move approval of proposed Section 9. (Motion was seconded and carried.)

Proposed Section 10:

"The Insurance Review Board shall provide a forum in which disputes between physicians, their patient-insureds, and insurance carriers can be mediated."

Mr. Speaker, I move the adoption of Proposed Section 10. (The motion was seconded; carried.)

Proposed Section 11:

"The Board of Managers of the McDowell House shall be responsible for the proper maintenance and operation of the McDowell House and Apothecary Shop under the general guidance of the Board of Trustees."

Mr. Speaker, I move the adoption of Proposed Section 11. (Motion seconded; carried.)

Proposed Section 12:

"The Memorials Commission shall endeavor to finance the furnishing of the Board Room and the President's Office, may accept memorial contributions to the Association and collect books, medical instruments and other memorabilia associated with the early practice of medicine for inclusion in the display on exhibition in the President's Office."

Mr. Speaker, I move adoption of proposed Section 12. (The motion was seconded and carried.)

Proposed Section 13 defines the duties of the Council on Scientific Assembly and is the same as the present Section 11.

Mr. Speaker, I move adoption of proposed Section 13. (Motion seconded; carried.)

Proposed Section 14:

"The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Association Education Research Foundation, and concerning itself with problems relating to *non-governmental* medical and hospital care, general practice, *research* and such other matters in this general field as may be referred to it by the Board."

This with minor changes is the present Section 12.

Mr. Speaker, we propose deletion of present Section 12 and move adoption of proposed Section 14. (Motion seconded; carried.)

Proposed Section 15, the Council on Legislative Activities, is the same as present Section 13.

Mr. Speaker, we propose deletion of present Section 13 and move the acceptance of proposed Section 15. (The motion was seconded; carried.)

Proposed Section 16:

"The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc. and Blue Cross plans. It shall serve as a clearing house on all *non-governmental* fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care *to all segments of the population through physician placement and other means.*"

The above proposed Section 16 supersedes present Section 14.

Mr. Speaker, I move the deletion of Section 14 and adoption of proposed Section 16. (The motion was seconded and carried.)

Proposed Section 17:

"The Council on Communications and Public Service shall supervise and direct all Associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, highway safety, disaster medical care and diabetes. *In addition, it shall assist the Board in presenting the Orientation Course referred to in Chapter I, Section 5.*

The above proposed Section 7 supersedes the present Section 15.

Mr. Speaker, I recommend the deletion of present

Section 15 and move adoption of proposed Section 17. (Motion seconded; carried.)

Proposed Section 18:

"The Council on Governmental Medical Services shall concern itself with all programs of medical care offered by governmental agencies, maintaining close liaison with the State Department of Health and other governmental units involved with such programs. It shall keep the Board of Trustees informed of all innovations in the field of governmental medicine and advise the Board as to any action which the Association should take with regard to such programs."

Mr. Speaker, I move the deletion of present Section 16 which concerns the Council on Allied Professions and Related Groups. (Motion seconded; carried.)

Mr. Speaker, I move the adoption of proposed Section 18. (Motion was seconded and carried.)

Mr. Speaker, I move adoption of Report #20 as a whole as amended. (Motion seconded; carried.)

Report of the Interim Meeting Program Committee

Your committee met Thursday evening, November 4, in Harrodsburg and in a lengthy session made careful plans for the 1966 Interim Meeting held at Cumberland Falls April 13 and 14.

The format for the 1966 meeting was altered at the direction of the Board of Trustees. The conference opened with a dinner meeting Wednesday evening at DuPont Lodge, a general session was held Thursday morning, and the conference closed with a luncheon meeting.

From an attendance point of view, the meeting was an outstanding success. An all-time high of 261 registered.

In formulating the program, the members of the committee felt that major emphasis should be placed on the implementation of PL 89-97. Special attention was given to utilization and review and other specifics of Title XVIII, Part B of the law.

Because of the very large attendance, some difficulty was experienced in adequately housing those in attendance. It was felt that more might have been present except for this problem.

Our committee wishes to express the appreciation of the members of KMA for the hospitality and full cooperation of the members of the Whitley County Medical Society who contributed in such a fine way to the success of the 1966 Interim Meeting.

INTERIM MEETING PROGRAM COMMITTEE
Hubert C. Jones, M.D., Berea
Lawrence U. Gilliam, M.D., Corbin
Robert E. Pennington, M.D., London
Everett H. Baker, M.D., Louisville,
Chairman

Recommendations, Reference Committee No. 6

Our committee reviewed the report of the Interim Meeting Program Committee and was pleased to note that a new attendance record was set at the 1966 Interim Meeting and that an excellent program was presented. Your reference committee commends the work done by this group.

Mr. Speaker, I move the adoption of this portion of the report. (Motion was seconded and carried.)

Report of the Insurance Review Board

The Insurance Review Board has been in existence for three years and has as its function to help control abuses of insurance and prepayment funds, whether committeed by physicians, utilizers of the services, or by the insurance and prepayment organizations.

We are pleased to report that we have not found it necessary to conduct a formal meeting this past year as no major problems have been referred to us for consideration.

It is anticipated that the activities of the Insurance Review Board will increase during the coming months. The KMA Board of Trustees has assigned to this Review Board the responsibility of working with representatives of The Metropolitan Life Insurance Company, Kentucky's carrier for Part B, Title XVIII, PL 89-97, for the purpose of adjudicating any problems associated with overcharging or over utilization not resolved at the local level.

INSURANCE REVIEW BOARD
Bernard J. Baute, M.D., Lebanon
Jack L. Chumley, M.D., Louisville
Harvey Chenault, M.D., Lexington
John Dickinson, M.D., Glasgow
Albert S. Irving, M.D., Louisville
Paul H. Klingenberg, M.D., South Fort Mitchell
William C. Mitchell, M.D., Louisville,
Chancellor

Recommendations, Reference Committee No. 6

Reference Committee #6 considered the report of the Insurance Review Board and noted that the 1965-66 year was a light one. It was observed, however, that the Board of Trustees had assigned the Review Board the responsibility of adjudicating problems which may arise with the carrier under Part B. Title XVIII, PL 89-97.

Mr. Speaker, I move the acceptance of the report. (Motion seconded; carried.)

Report of the Council on Medical Services Page 2, Paragraph 3

Members of this council also discussed the recommendations made and approved by the Board of Trustees of a study made of the KMA council and committee structure. This council is in complete agreement with these changes which are being proposed by the Constitution and Bylaws Committee and feels that this association will be in a position to do a better job for all Kentuckians if these changes are approved.

Recommendation, Reference Committee No. 6

This paragraph was referred to Reference Committee No. 6 and concerned the recommendations made and approved by the Board of Trustees of a study made of the KMA council and committee structure. Since these changes have been implemented in Report #20, no further action is decmed necessary on this portion of Report #14.

Mr. Speaker, I move the acceptance of this portion of the report. (Motion seconded; carried.)

Report of the Council on Allied Professions and Related Groups Page 14, Paragraph 2

2. The AMA Council has changed its name to Council on Occupational Health which the committee felt is more inclusive and up-to-date. We recommend that the name of the KMA Industrial Medicine Committee be changed to Committee on Occupational Health.

Recommendation, Reference Committee No. 6

The AMA Council has changed its name to the Council on Occupational Health, which the KMA Council feels is more inclusive and up to date. The Council on Allied Professions and Related Groups has recommended that the name of the KMA Industrial Medicine Committee be changed to Committee on Occupational Health. Since these changes have been implemented in Report #20, no further action is deemed necessary on this portion of Report No. 16.

Mr. Speaker, I move the adoption of this portion of the report. (Motion seconded; carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 6 as a whole. (The motion was seconded and carried.)

Mr. Speaker, as chairman of Reference Committee No. 6, I wish to express my deep appreciation for the excellent work done by the members of the Committee and for the fine staff work done by Mrs. Pat Hire in transcribing the report of Reference Committee No. 6.

REFERENCE COMMITTEE NO. 1
John M. Baird, M.D., Danville
Eugene L. Marion, M.D., Glasgow
Robert McClendon, M.D., Louisville
J. M. Stevenson, M.D., Brooksville
W. Vinson Pierce, M.D., Covington,
Chairman

REFERENCE COMMITTEE NO. 7†

Irving F. Kanner, M.D., Chairman

Miscellaneous Reports

See Note (†) bottom of column one, Page 1122.

Reference Committee No. 7 considered the following reports:

25. Report of McDowell House Committee
26. Report of Memorials Commission
28. Report of KMA Representative to Conference of Presidents and Other Officers of State Medical Associations
29. Report of KMA Representatives, University of Kentucky Chapter, Student AMA
30. Report of KMA Representative, Unviersity of Louisville Chapter, Student AMA
32. Report of KMA Representative, Advisory Committee on Maternal and Child Health, State Department of Health

Resolution F—Selective Service.

Report of the McDowell House Committee

During the past year, the McDowell House Committee met in Danville on four occasions for the purpose of supervising the maintenance of the house and its operation for the benefit of the public. Considerable attention has been paid to its further usefulness and to methods of future operation.

Fortunately no major repairs have been necessary during the past year, although they are required at intervals. The state of the House is in good condition; gradual improvements and addition of various items have made this one of the outstanding medical and artistic exhibitions in the country.

Within the past year, the Department of Interior has named the McDowell House a National Shrine. On September 29, 1965, Mr. Paul McMiller of the Department of Interior gave an address at the home in honor of this designation and a plaque was presented by the Department which has been installed in the House.

Contributions for the upkeep of the House since January 1, 1966, have been deposited in a Danville bank, both for convenience in depositing the daily income from admission fees and in order that the financial state of the House may be evident at all times. Expenditures are authorized and paid by the Treasurer of the Kentucky Medical Association.

Much discussion has centered around the possibility of offering annual memberships of various types to interested individuals over the country, as is being done with most Historic Houses. Not only would this method of raising funds stimulate a broader interest in the dramatic accomplishments of Ephraim McDowell, but it may eventually relieve the Association of financial obligations.

In May, 1966, an exhibit of items from the McDowell House with accompanying photographs was presented at the meeting of the American College of Obstetricians and Gynecologists in Chicago. A large number of people visited the exhibit and many left their names as friends of McDowell House. A Special Award of Merit was presented for this exhibit. The same exhibit is scheduled for the Kentucky Medical Association's Annual Meeting.

Of particular interest is the addition of two new nonmedical members to the Committee this year (now a total of four nonmedical members), namely, Mr. James Cogar, formerly curator at Williamsburg, Virginia, and at present engaged in the restoration of Shakertown, and Mr. Enos Swain, editor of the local newspaper at Danville. Mr. Cogar acts as official advisor in matters of arrangement, taste, maintenance, and furnishings which are being contributed. Mr. Swain offers valuable advice and his particular talent in the preparation of pamphlets, books, and publicity.

Through the efforts of Doctor Massie, the original portrait of McDowell by John Davenport was returned from the Kentucky Historical Society where it had been on loan for a long time. This portrait was obtained many years ago by Dr. Arthur McCormick from the descendants of McDowell residing in Kansas.

Your committee is honored to be entrusted with the care of this important Shrine.

MCDOWELL HOUSE COMMITTEE
Laman A. Gray, M.D., Louisville, Chairman
Robert C. Bateman, M.D., Danville
B. B. Baughman, M.D., Frankfort
Rankin C. Blount, M.D., Lexington
Mr. Sterling Coke, Lexington
Mr. James L. Cogar, Harrodsburg
Dr. Norman Franke, Lexington
Mr. George Grider, Danville
E. M. Howard, M.D., Harlan
Richard H. Segnitz, M.D.
Mr. Enos Swain, Danville

Recommendations, Reference Committee No. 7

The McDowell House Committee Report covers the work of the last year during which many changes have been made both in the McDowell House and in the addition of members to its committee. The McDowell House this past year has been designated as a National Shrine by the Department of Interior.

"Mr. Speaker, we move the adoption of this report." (Motion seconded and carried.)

Report of the Memorials Commission

It was reported at the meeting of your K.M.A. Memorials Commission held April 6, 1966, that the members of the Board of Trustees and other officers of our Society have contributed a total of 30 chairs to the Board Room of the Headquarters Building.

G. Y. Graves, M. D., of Bowling Green, presented the K.M.A. with three boxes of 19th century surgical instruments. The Memorials Commission was pleased to accept these interesting gifts from our fellow Commission member. The boxes will be labeled and put on display in the miniature museum in the President's office.

The Memorials Commission is very much interested in obtaining representative examples of older diagnostic or surgical instruments for permanent display, and books and manuscript materials from the mid 19th century.

It was reported to the Commission that there was now $1,800.00 in the Library-Museum Fund which the Commission expects to use in building up the library museum. This figure represents an accumulation of $700.000 in the past year which has been contributed by past presidents or their heirs. During this past year there have been five additional chairs

donated for the Board Room.

The Commission gave full consideration to further promoting the aims of the library museum. A bookcase, suitable for use in the display of museum exhibits was purchased by the Commission. A exhibit of some of the museum items and books is planned for the forthcoming K.M.A. Annual Meeting. Your Chairman, with the consent of the Board, will be presenting a promotional discussion of the aims and purposes of the Library Museum in an issue of the K.M.A. Journal early in the fall of 1966.

MEMORIALS COMMISSION
G. Y. Graves, M.D., Bowling Green
J. Duffy Hancock, M.D., Louisville
Francis Massie, M.D., Lexington
J. M. Stevenson, M.D., Brooksville
Eugene H. Conner, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 7

A number of interesting gifts have been received by the commission and placed on display in the Library Museum. The commission is interested in obtaining representative examples of older diagnostic or surgical instruments for permanent display and books and manuscript materials from the Mid-19th Century.

"Mr. Speaker, we move the adoption of this report." (Motion seconded and carried.)

Report of the Conference of Presidents and Other Officers of the State Medical Associations

The 22nd Annual Meeting of the Conference of Presidents and Other Officers of the State Medical Associations was held June 26 in the Palmer House, Chicago. Conference President, Walter C. Bornemeier, M.D., Chicago, called the session to order at 9:30 a.m. and an informative presentation by the President-Elect, Thurman B. Givan, M.D., Brooklyn, followed. A short business meeting was then held.

The conference was then highlighted by two outstanding addresses. Former Vice-President of the United States, Richard M. Nixon, gave a stimulating talk entitled "Which Way America?" which provided much thought for the conference participants.

Doctor Angus Murray, President of the Australian Medical Association, delivered the closing address entitled "How We From 'Down Under' Got Out From Under" in which he outlined how Australia, which was at one time under government medicine, restored themselves to the free practice of medicine.

Adjournment of the conference came at 11:30 a.m.

Respectfully submitted,
Everett H. Baker, M.D., President
Kentucky Medical Association

Recommendations, Reference Committee No. 7

Doctor Baker's report includes an interesting mention of Doctor Angus Murray's address to the conference of how Australia restored itself to the free practice of medicine.

"Mr. Speaker, we move the adoption of this report." (Motion seconded and carried.)

Report of the KMA Representative, U of K Chapter, Student AMA

The following is a resume of the activities of the Kentucky Chapter of the SAMA:

1. The Chapter sponsored two meetings during the year that were open to the University community during which time, well known speakers on medical topics were presented.
2. A series of approximately ten films on medical topics were presented to the medical student body.
3. A research manual was published listing the summer fellowships open for the students of the College of Medicine.
4. The Chapter sponsored an Awards Day in May of 1966 for the purpose of recognizing outstanding student research projects. This was an event for the entire student body and faculty.
5. A curriculum evaluation of each course was presented to interested faculty by the Chapter.
6. During the academic year, a local clinicopathological conference contest was held for the entire student body.
7. The SAMA maintained liaison with the local pre-medical student organization and participated in some of their meetings.
8. SAMA sponsored a fall picnic for the entire student body, at which time entering freshmen were given an opportunity to meet the other students. In addition, a spring dance was held for the student body, during which time a lampoon of the faculty was presented.

Donald E. Edger, M.D., KMA
Representative U of K Chapter

Recommendations, Reference Committee No. 7

Doctor Edger's report shows the Student AMA Chapter of the University of Kentucky had an extremely active and productive year.

"Mr. Speaker, we move the adoption of this report." The motion was seconded. David B. Stevens, M.D., of the Fayette County Medical Society asked to include in this report that the Women's Auxiliary to the U of K SAMA Chapter was awarded a prize as the outstanding chapter in the country. The motion carried.

Report of the KMA Representative, U of L Chapter, Student AMA

This has been a stellar year for the University of Louisville Chapter of the Student AMA. It has been particularly so because we have had the distinction of having James Moss as President of SAMA. His performance has brought considerable dignity to the organization and has certainly brought much pride to our school that we could be a sponsor of a young man with such high talent.

Our local chapter has been busy in the usual affairs, and we are particularly pleased with the efforts of WA-SAMA headed by Margie Buckner, who has held monthly meetings at which time discussions on various ancillary aspects of medicine were held. The membership of the local WA-SAMA chapter has tripled during her term as president.

Our local chapter had representatives at the Southern Regional meeting in Nashville and took active parts in the program.

Brennan Cassidy represented our U of L at the National Convention in Los Angeles and did a most commendable job and served on two of the committees.

Ted Buckner has been elected as next year's president for the U of L Chapter and we are looking forward to another excellent year.

We are particularly fortunate to have such a strong chapter at the University of Louisville and is so recognized across the country as having had many distinguished leaders in the past, culminating in Jim Moss' election to the Presidency. Because of the ebullient fashion that they pursued the responsibilities of this organization, it is felt that we shall continue to see many more strong leaders evolve in the future from here.

The Kentucky Medical Association was pleased to help sponsor our membership trip to Los Angeles and we are very pleased with the type of performance that these young future doctors are giving.

Next year's national convention will be in Chicago, and we are looking forward to some more of the same excellent record.

Hoyt D. Gardner, M.D., KMA
Representative of U of L Chapter

Recommendations, Reference Committee No. 7

Doctor Gardner reports that the University of Louisville Chapter, Student AMA has been equally busy and particularly notes the growth of its Women's Auxiliary.

"Mr. Speaker, we move the adoption of this report."

The Reference Committee notes that the Kentucky Medical Association financially sponsored the attendance of representatives from the two Chapters to the National Convention and recommends that this be continued.

"Mr. Speaker, we, therefore, move the KMA again sponsor the representative from each of the two Student AMA Groups to the National Convention." (Motion seconded and carried.)

Report of the Representative Advisory Committee on Maternal and Child Health State Department of Health

No report received

Recommendations, Reference Committee No. 7

No report was received from the representative of the Advisory Committee on Maternal and Child Health of the State Department of Health. The Committee notes that excellent and thorough reports were received by the Council on Allied Professions and Related Groups both from the Maternal Mortality Study Committee and from the Peri-Natal Mortality and Morbidity Study Committee and these are included in Report No. 16.

"Mr. Speaker, we move that in the future the report of the representative of the Advisory Committee on maternal and child health be combined with reports from the above-mentioned committees." (Motion seconded and carried.)

Resolution F

Muhlenberg County Medical Society

WHEREAS the State Department of Health has released statistics indicating that there are approximately 90 physicians in Kentucky for each 100,000 people; and

WHEREAS in many counties there are fewer than 90 physicians per 100,000 population, for instance in Muhlenberg County there are less than half this many per 100,000 population; and

WHEREAS physicians are subject to Selective Service in the Armed Forces of the United States under nebulous standards upon which selections are made; and

WHEREAS the mathematical ratio of physicians to total population would seem to furnish a reliable index to the need for a physician in a given area, and the use of such an index would be consistent with the efforts of the Commonwealth of Kentucky (through its appropriations to the Rural Kentucky Medical Scholarship Fund) to secure physicians for areas in which there is a shortage of physicians,

NOW THEREFORE, BE IT RESOLVED BY THE HOUSE OF DELEGATES OF THE KENTUCKY MEDICAL ASSOCIATION that this House endorses the concept of determining the availability of physicians for service in the Armed Forces on the basis of the number of physicians in a given population area (the county being a convenient unit of population) and recommends to the Selective Service System that eligible physicians whose ages fall within the age limits desired in a given call, be called in sequence beginning in counties with the most satisfactory ratio of physicians to patient population, and proceeding to those counties with a less desirable ratio, and that the ratio of physicians to lay population in each county be the only criterion for selecting physicians in a given county.

Recommendations, Reference Committee No. 7

The Reference Committee discussed this resolution in depth and agreed in principle. It felt, however, that the simple ratio of physician to patient population in a community might not always represent a fair proportion of active physicians, since a county might have a large percentage of its physicians ill or retired. In addition, it felt that although the ratio of active physicians to lay population in a county should be a major criteria in selecting physicians for service, it should not be the only criteria.

We move the amendment of Resolution F as follows:

> the addition of the word "active" before the word "physicians," the substitution of the word "major" for the word "only" at the end of line 11 in the same paragraph.

"Mr. Speaker, I move the adoption of this portion of the report." (Motion seconded and carried.)

"Mr. Speaker, I move the adoption of the report of the Reference Committee No. 7 as a whole." (Motion seconded and carried.)

I would like to thank the members of the Reference Committee who served with me and the physicians who commented at the meeting.

REFERENCE COMMITTEE NO. 7
Harvey Page, M.D., Pikeville
W. Fielding Rubel, M.D., Louisville
James G. Sills, M.D., Hardinsburg
Loman Trover, M.D., Madisonville
Irving F. Kanner, M.D., Lexington.
Chairman

Unfinished Business

Doctor Greathouse recognized Hubert C. Jones, M.D., chairman of the Board of Trustees for the final report of that group. The report follows:

"The Judicial Council has just completed its first full year of work after having been elected by this House of Delegates. You will recall that the terms of four members were staggered so that a vacancy on the Council would take place every year. The first vacancy on the Council is for the position now held by Hugh L. Houston, M.D., Murray.

"According to the Bylaws, Chapter VII, Section 1, 'to be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.'

"The Bylaws further provide that the Board of Trustees shall nominate at least one candidate for each vacancy and that additional nominations may be made from the floor.

"The Board of Trustees has voted unanimously to nominate to you, John Dickinson, M.D., Glasgow, Kentucky, to succeed Hugh L. Houston, M.D."

Doctor Jones moved the adoption of the report. The motion was seconded and carried.

Election of Officers

The Vice-Speaker called for the report of the Nominating Committee, which was presented by its Chairman, W. Vinson Pierce, M.D., Covington. Doctor Pierce read the following list of nominations for the positions to be filled as follows:

President-Elect	George F. Brockman, M.D., Greenville
Vice-Presidents	
Central	Roy H. Moore, Jr., M.D., Louisville
Eastern	J. Campbell Cantrill, M.D., Georgetown
Western	James W. Harris, M.D., Paducah
Secretary	Henry B. Asman, M.D., Louisville
Treasurer	Keith P. Smith, M.D., Corbin
Speaker of the House	Richard F. Greathouse, M.D., Louisville
Vice-Speaker	Carl Cooper, Jr., M.D., Bedford
AMA Delegate	J. Thomas Giannini, M.D., Louisville
AMA Alternate Delegate	Charles G. Bryant, M.D., Louisville

After each nomination was presented, the Vice-Speaker called for nominations from the floor. No nominations were received and it was moved and seconded that the nominees be elected. Motion carried.

The following nominations for the offices of trustees were submitted by Doctor Pierce:

Fifth District	George A. Sehlinger, M.D., Louisville
Sixth District	Rex E. Hayes, M.D., Glasgow
Eighth District	LeRoy C. Hess, M.D., Florence
Eleventh District	Douglas H. Jenkins, M.D., Richmond
Fourteenth District	Ballard W. Cassady, M.D., Pikeville
Fifteenth District	E. C. Seeley, M.D., London

The same procedure followed in electing the general officers was followed in the election of the trustees. Since there were no nominations from the floor, the above-named nominees were elected.

Doctor Brockman, the new president-elect, was escorted to the rostrum. He received a standing ovation.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was submitted and received for information only:

John Dickinson, M.D., Glasgow
John D. Gordinier, M.D., Louisville
J. Duffy Hancock, M.D., Louisville
Coleman C. Johnston, M.D., Lexington
Thomas O. Meredith, M.D., Harrodsburg
Wyatt Norvell, M.D., New Castle
Richard J. Rust, M.D., Newport
Garnett J. Sweeney, M.D., Liberty
George P. Archer, M.D., Prestonsburg
Charles J. Bisig, M.D., Louisville
Donald K. Dudderar, M.D., Newport
William W. Hall, M.D., Owensboro
James M. Keightley, M.D., Harrodsburg
John C. Quertermous, M.D., Murray
Keith P. Smith, M.D., Corbin
Stanley Smith, M.D., Louisville
Karl C. Kelty, M.D., Lexington
Carroll H. Robie, M.D., Louisville

Election of 1967 Nominating Committee

The Nominating Committee to serve at the 1967 Annual Meeting was elected as follows:

John S. Ashworth, M.D., Ashland
Harold B. Barton, M.D., Corbin
Robert L. McClendon, M.D., Louisville
Andrew M. Moore, M.D., Lexington
W. Vinson Pierce, M.D., Covington

Robert E. Pennington, M.D., London, was installed as President, the oath of office being administered by the Chairman of the Board of Trustees. Hubert C. Jones, M.D. President Pennington presented the Past President's Plaque to the retiring president, Doctor Baker.

The newly installed President made brief remarks to the members of the House of Delegates. Doctor Greathouse thanked the members of the House of Delegates for their cooperation during both sessions. The second session of the 1966 House of Delegates was adjourned at 10:15 p.m.

against the usual gram-negative urinary pathogens

Why use five...where **one** will do?



In a recent 217-patient hospital study,[1] urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients)... and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent



Coly-Mycin® Injectable
(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa.*

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against Proteus.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

Full information is available on request.

01-QP-69-R2

WARNER-CHILCOTT Morris Plains, New Jersey



CONSIDER **DEXAMYL**® FIRST
brand of dextroamphetamine sulfate and amobarbital

Often within the hour, 'Dexamyl' works to help dispel such symptoms as apathy, pessimism, loss of interest and initiative, and lack of ability to concentrate.

Formulas: Each 'Dexamyl' Spansule® capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*.

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Do not use in patients taking MAO inhibitors. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester. *Side effects:* Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

SK&F SMITH KLINE & FRENCH LABORATORIES

ORGANIZATION SECTION

House Approved Usual and Customary Confidential Fee Survey to be Made Soon: Reasons for Delay Explained*

Plans are moving ahead for the confidential surveying of physicians' fees in Kentucky, in order that it may be possible to learn what the usual and customary fee is. The study was authorized by the KMA House of Delegates, September 21, and will be conducted jointly by the Kentucky Blue Shield Plan and the State Department of Health, with the cooperation of the Kentucky Medical Association.

The survey was recommended in Resolution A, introduced by the KMA Board of Trustees. In a meeting September 18, the Board of Directors of Kentucky Physicians' Mutual, Inc., (the Blue Shield Plan for Kentucky), Resolution A as written by the KMA Board of Trustees was considered and approved in its original form.

Delay in implementing Resolution A occurred when the Fayette County and the Jefferson County Medical Society amendments to the resolution were accepted by the House of Delegates. It was then necessary to take the amended resolution back to the Blue Shield Board for reconsideration. At its November 10 meeting, the Blue Shield Board voted to go ahead with the amended resolution.

When Title XIX of Public Law 89-97 was implemented in Kentucky, the State Department of Health regulations called for a schedule of fees that varied according to whether or not the provider of the services was a specialist or non-specialist. Department officials said the fixed fee schedule was necessary in order to budget the cost of the program.

According to KMA President, Robert E. Pennington, M.D., "A large number of physicians in private practice contend it would be more economical for the physicians participating in the program to be paid their usual and customary fees for services rendered". He pointed out that in order to substantiate this contention, such a schedule as approved by the House of Delegates would have to be made.

Because of its expert experience and availability of data processing equipment, the KMA Board of Trustees turned to the Blue Shield for assistance. Representatives of Blue Shield and the State Department of Health met with the Board of Trustees in the late summer to consider the feasibility of such a survey. It was agreed by all that in order for the survey to have credibility, it would have to follow accepted procedures similar to those established by the Blue Shield in its Jefferson County Medical Society Survey, and that at least 75 per cent of Kentucky physicians should participate.

Agreement was reached that provided for the joint sharing of this costly survey by the Blue Shield and the State Department of Health, working in close cooperation with the KMA. It was also agreed that the results of the survey would be confidential.

Russell E. Teague, M.D., Commissioner of Health, said the Department was not interested in names, but only in figures that established the "range of fees". With this information, it would be possible for his Department to learn the predictability of costs. With this accomplished, he hopes to develop changes in the Medical Welfare Program that will be satisfactory.

Full information on the Survey will be sent physicians at the earliest possible date. Hopefully, with physician cooperation, the survey will be completed by May 1.

**See page 1170, this issue for full text of Resolution A and House action.*

1st KMA Trustee District Meeting Jan. 25, Paducah

January 25 has been set as the date of the 1967 First KMA Trustee District Annual Meeting, at Paducah, according to District Trustee, Joseph R. Miller, M.D., Benton.

The McCracken County Society will be the host group for the Meeting to be held at the Paducah Country Club. The District Women's Auxiliary will meet jointly with the physicians.

The featured speaker at the Meeting will be Robert E. Pennington, M.D., London. Mrs. Raymond E. Jones, Louisville, president of the Women's Auxiliary will attend the meeting also.

Dr. Miller said that each member will receive a personal invitation to the meeting.

Chairs AMA Reference Committee

J. Thomas Giannini, M.D., Louisville, Delegate from KMA to the AMA, served on Reference Committee "E" at the 1966 AMA Interim Meeting held at Las Vegas, November 20-30.

Decision to Increase AMA Dues $25 Came After Careful Study

The decision to increase the Annual Dues on January 1, 1967 from $45 to $70 by the American Medical Association House of Delegates at its 1966 Annual Meeting came after seven months of intensive study and full consideration, not only by the AMA itself, but also by the constituent associations.

The reference committee report, recommending the increase in dues, which was passed by a substantial majority said "It is quite apparent that the programs necessary to serve the needs of the members of the Association cannot be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the Board of Trustees".

The report continued "It is fully cognizant of the responsibility of the House of Delegates and of the Board of Trustees to keep the expenses of the Association to the minimum commensurate with the accomplishment of its goals. It is equally conscious of the responsibility of the House of Delegates and of the Board of Trustees to carry out the mandate of the members to the end that the medical profession in the United States be effectively represented and that the cause of medical science and the health care of the public be protected and promoted".

In order that full consideration could be given the problem of adequate financing of AMA programs as developed by its governing bodies, the House of Delegates at the 1965 Clinical meeting in Philadelphia, voted tentative approval to the 1967 dues increase, but urged its delegates to go home and consider the matter with the state associations they represented before taking final action in June of 1966.

The matter was considered at length by the members of the KMA Board of Trustees after which it voted to authorize the KMA Delegation to the AMA to support the increase.

KMA Interim Meeting, April 19-20 to be Held at Ken-Bar Inn

The 17th KMA annual Interim Meeting will be held at beautiful Ken-Bar Inn Resort at Gilbertsville, Kentucky, just west and adjacent to Kentucky Dam Village State Park, Wednesday and Thursday, April 19 and 20, 1967.

According to Robert E. Pennington, M.D., London, KMA president and chairman of the Interim Meeting Program Committee, an excellent program is being planned. It is expected that full details will be announced in an early issue of this Journal.

"With the continuing growth of interest in this important meeting, we will, for the first time in many years, be able to offer attractive, adequate housing in close proximity to the meeting rooms", Doctor Pennington said. He pointed out that there will be more than enough first class bedrooms, deluxe cottages available. It is expected that many members will plan a weekend vacation in connection with the meeting and enjoy the fishing, golf and other attractions of the popular park and resort area.

Dr. Robertson New President of Blue Shield Plan for Kentucky



Dr. Rust



Dr. Robertson

Robert W. Robertson, M.D., Paducah, was elected president of the Board of Directors of Kentucky Physician's Mutual, Inc. (Blue Shield Plan for Kentucky), to succeed Richard J. Rust, M.D., Newport, at the Annual Meeting of the Board in Louisville, November 11.

Garnett J. Sweeney, M.D., Liberty, was elected first vice-president; Wyatt Norvell, M.D., New Castle, second vice-president; J. P. Sanford, Louisville, secretary and Branham B. Baughman, M.D., Frankfort, treasurer.

D. Lane Tynes, Louisville, who is president of the Kentucky Blue Cross Plan was re-elected executive director, Stanley T. Simmons, M. D., Louisville, was elected medical consultant and Miss Joyce Carter, Louisville, was re-elected assistant secretary.

At the conclusion of Doctor Rust's two year term of office, November 11, the Board unanimously passed a special action expressing appreciation for the excellent leadership Doctor Rust provided during that time.

After Hours Medical Center Is Working Well at Henderson

An "After Hours Medical Center" has been established by six physicians in private practice at Henderson, Kentucky and has been working successfully since it was established about October 1, according to a report by Kenneth Eblen, M.D., Henderson, past KMA vice-president.

The purpose of the Center, Doctor Eblen says, is to provide the patient with a physician twenty-four hours a day, 365 days a year and to provide participating physicians with time off they would not otherwise enjoy. The physicians rotate their services and see all patients, except those that need emergency medical care that should be provided in hospitals.

The Center is located in a shopping center at Henderson. It is fully equipped and has a TV for waiting patients to view. Some drugs are dispensed only when pharmacies are closed.

Each patient is given a "slip" made out in "quadruplicate". One copy is kept for the Center's record, one is sent to the patient's regular physician, one copy to the physician who treated the patient and the fourth to the patient as a receipt.

Both patients and physicians seem well pleased with the Center. As far as it is known, Hammond, Indiana has the only other center of its kind now in operation, Doctor Eblen said.

Dr. Long, AMA Executives Visit Vietnam, Manila Meeting

Robert C. Long, M.D., Louisville, left the U.S. on October 29, enroute to Vietnam and Manila, Philippines. He accompanied Charles L. Hudson, M.D., president of the AMA, James Z. Appel, M.D., immediate past president and L.O. Simenstad, M.D., a member of the Board of Trustees of the AMA, on a one week "on sight survey" of two AMA programs being carried on in Vietnam.

The two AMA Vietnam programs are the Agency of Education Development, a program to strengthen education, supported in part by the State Department, and the AMA Volunteer Physicians Program. This trip is a continuation of an earlier visit to Vietnam, by Doctor Long and other AMA representatives, in February and March of this year.

Also in the group visiting Vietnam is Leo Brown, assistant to the executive vice-president of the AMA.

Upon leaving Vietnam, the physicians were scheduled to go to Manila to attend the World Health Association Assembly, November 6-12. Doctor Long has been asked to read three scientific papers during the Assembly in Manila. The entire trip was to take three weeks, after which the physicians were scheduled to return to the U.S.

Drs. Hamburg, McBeath Appointed at UK Medical Center

Joseph Hamburg, M.D., Lexington, a member of the faculty of the University of Kentucky College of Medicine since 1963, has been appointed to the position of first dean of the University's new school for Allied Health Personnel. The School was established as part of the U of K Medical Center last January.

The new school now offers or is preparing to offer instruction in ten different programs, including laboratory technology, physical therapy, residency training, and more.

At the same time the trustees appointed William McBeath, M.D., as special assistant to William Willard, M.D., vice-president of the Medical Center.

Dr. Griffen to Succeed Dr. Eiseman As UK Head of Surgery

Ward O. Griffen, Jr., M.D., associate professor of Surgery and of Physiology at the University of Kentucky, has been appointed to succeed Ben Eiseman, M.D., as Chairman of the Department of Surgery of the University's College of Medicine, effective July 1, 1967. John Oswald, president of UK, announced the appointment after Doctor Eiseman disclosed his intention to return to Denver next year.



Dr. Griffen

Doctor Eiseman has been with the University for the past six years and was the department's first chairman. He came to Kentucky from Denver where he was a professor of surgery and acting dean at the University of Colorado School of Medicine.

Doctor Griffen came to UK from the University of Minnesota Hospital, where he was an assistant professor of surgery and the director of the artificial kidney service. He graduated from Cornell University Medical College in 1953, completed his internship at Bellevue Hospital, New York, and University of Minnesota Hospitals, Minneapolis, in 1954. He completed two residencies, one in 1957 and one in 1962, at the University of Minnesota Hospitals.

Forty-Six Ky. Physicians Attend SMA Meeting Nov. 14-17

Forty-six Kentucky physicians attended the 60th annual meeting of the Southern Medical Association in Washington, D.C., November 14-17, according to registration information received from SMA.

Oscar B. Hunter, Jr., M.D., Washington, D. C., was chosen president-elect. Guy T. Vise, M.D., Meridian, Miss., was installed as president, succeeding J. Garber Galbraith, M.D., Birmingham, Ala., the retiring president.

J. Duffy Hancock, M.D., Louisville, serves on the SMA Board of Trustees and Sam A. Overstreet, M.D., is on the SMA Council.

Kentucky physicians registered at the meeting were:

William H. Anderson, M.D., Louisville
William H. Barnard, M.D., Elizabethtown
Malcolm Barnes, M.D., Louisville
C. M. Brasfield, M.D., Elizabethtown
Glenn W. Bryant, M.D., Louisville
W. M. Buttermore, M.D., Corbin
Ruth M. Coppedge, M.D., Hopkinsville
Rachel G. Croft, M.D., Hopkinsville
W. Burford Davis, M.D., Louisville
Ralph M. Denham, M.D., Louisville
Roy K. Diamond, M.D., Louisville
O. T. Evans, M.D., Lexington
F. F. Ferguson, M.D., Madisonville
Malcolm H. Fine, M.D., Louisville



Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

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Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

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Above is pictured the Annual Fall Board Meeting of the Women's Auxiliary of KMA, held in the Board Room at the Headquarters office, November 1.

Carl M. Friesen, M.D., Lexington
John D. Gordinier, M.D., Louisville
George Gumbert, Jr., M.D., Lexington
J. Duffy Hancock, M.D., Louisville
Harry A. Hamilton, M.D., Corbin
Douglas M. Haynes, M.D., Louisville
Clifford N. Heisel, M.D., Covington
Joseph Humpert, M.D., Fort Mitchell
David H. Johnston, M.D., Lexington
W. M. King, M.D., Louisville
Ferris I. Larsen, M.D., Earlington
Ullin W. Leavell, Jr., M.D., Lexington
Ronald Leon Levine, M.D., Louisville
Paul Mapother, M.D., Louisville
J. B. Marshall, M.D., Louisville
Richard B. McElvein, M.D., Lexington
Robert F. Monroe, M.D., Louisville
Andrew M. Moore, M.D., Lexington
Charles T. Moran, M.D., Louisville
Horace Norrell, M.D., Lexington
Sam A. Overstreet, M.D., Louisville
Eugene Q. Parr, M.D., Lexington
W. Vinson Pierce, M.D., Covington
Gradie R. Rowntree, M.D., Louisville
Marjorie Rowntree, M.D., Louisville
B. F. Rush, M.D., Lexington
William J. Sandman, Jr., M.D., Louisville
F. S. Sigda, M.D., Madisonville
R. M. Slabaugh, M.D., Lexington
Keith P. Smith, M.D., Corbin
Thomas G. Stigall, M.D., Louisville
Edgar D. Wippermann, M.D., Covington

Lexington Conference, March 30

The Twelfth Annual Conference of the Lexington Clinic will be held on March 30, 1967. The theme of the day-long program will be "Medical and Surgical Problems of the Aged", according to C. H. Nicholson, M.D., Chairman of the Annual Spring Conference Committee.

WA-KMA Holds Fall Conference, Board Meeting Nov. 1

State officers, county presidents and presidents-elect of the Women's Auxiliary to KMA met Tuesday, November 1 for their annual Fall Conference in the Board Room at the KMA Headquarters office.

Mrs. Raymond Jones, M.D., Louisville, Auxiliary president, presided at the meeting.

The conference program was held in the morning, and the afternoon was devoted to the routine meeting of the Board.

The members viewed a film concerning Venereal Disease among teen-agers, and heard Miss Virginia Durrett, representative of the Louisville-Jefferson County Health Department, speak on VD. The program was in keeping with the Auxiliary's emphasis on community service by its members during the coming year.

Ky. Physicians Attend Congress On Medical Quackery, in Chicago

December Medical Journal 8 TR X17 Wanda Gentry

Three Kentucky physicians attended the recent AMA Third National Congress on Medical Quackery, held in Chicago.

J. Campbell Cantrill, M.D., Georgetown, KMA vice-president for the Eastern District, presented a paper at the meeting.

Frederick R. Scroggin, M.D., Williamsburg, who serves as a member of the AMA Congress on Medical Quackery, presided at the day-and-a-half session.

David B. Stevens, M.D., Lexington, who Chairs the KMA Committee on Cults, along with Gilbert L. Armstrong, director of field services for KMA, also attended the meeting.

Mrs. Glaser Named to Head Nurses At KNA Annual Meeting

Mrs. William Glaser, Assistant Educational Director of St. Joseph's Infirmary, Louisville, was elevated to President of the Kentucky Nurses Association at its Annual Meeting in Lexington late in October.



Mrs. Glaser succeeds Mrs. Nadine Turner, Superintendent of Nurses of Murray Kentucky Hospital.

Robert E. Pennington, M.D., represented the KMA at the KNA banquet held at the Phoenix Hotel.

Mrs. Glaser has long been active in association work and has chaired its legislative committee and other groups.

Nursing Home Association Elects Officers at Annual Meet

Leon Kingsolver, Danville, was elected president of the Kentucky Association of Nursing Homes and Personal Care Homes during the association's 13th annual meeting in Louisville in November.

Other officers elected at this year's meeting, which was attended by 230, include: Jamie Miller, Lexington, first vice president; Robert Keefer, Highland Heights, second vice president; Ira O. Wallace, New Castle, third vice president; Mrs. Ola Peacock, Owensboro, secretary; and Mrs. Edward Elliott, Springfield, treasurer.

Featured speaker was Ed Walker, Miami, Ohio, president of the American Nursing Home Association, who called conditions for participation in the Medicaid program (Title 19 of the Social Security Act) "too severe for the average nursing home". The next annual meeting will be in Owensboro on a date which will be set later.

New UK Biology School Named For Famous Ky. Scientist

John W. Oswald, president of the University of Kentucky, has announced that the new U. of K. School of Biological Sciences will be named for Thomas Hunt Morgan, a graduate of the University who became one of the world's leading geneticists and won the Nobel Prize for medicine and physiology in 1933.

The announcement was made at a banquet ending a three-day symposium on genetics which honored the 100th. anniversary of Morgan's birth. About one-hundred-and-fifty leading geneticists, physiologists and biologists throughout the world attended the symposium.

Dr. Oswald also announced that distinguished scholars will be appointed to "Thomas Hunt Morgan professorships in biology", and fellowships and scholarships honoring the Lexington scientist will go to the best graduate and undergraduate in biology.

Frank F. Conti, M.D., formerly of Dartmouth College, is director of the new school, which includes departments of botany, microbiology, zoology, biochemistry, cell biology, physiology and biophysics.

Plans for Senior Day Announced

The KMA Senior Day Committee met on November 10 and finalized the programs for the 1967 Senior Day sessions for the University of Louisville and the University of Kentucky senior medical students. The Thirteenth Annual U. of L. program was set for Monday, March 20 in Louisville, while the Fourth Annual U. of K. program was scheduled in Lexington for Tuesday, April 11.

Sponsored by KMA in conjunction with the Fayette County and Jefferson County medical societies, these affairs are highlighted by members of KMA making presentations throughout the day designed to help the medical student in his transition into the practice of medicine. Each session also includes an outstanding guest speaker at the program's closing dinner. The committee agreed to follow a similar format to that used in previous years.

No. Ky. Seminar Slated for Jan. 19

The Northern Kentucky Seminar, sponsored by the Kentucky Academy of General Practice, has been scheduled for Thursday, January 19, at Holiday Inn Cincinnati South, South Fort Mitchell.

The day-long meeting will begin with registration at 9:00. The program, according to Carl J. Brueggemann, M.D., Chairman, will include such topics as "Obstructive Airway Disease", Ronald Fragge, M.D., Covington: "Common Orthopaedic Problems Seen by the General Practitioner", Robert Runde, M.D., Covington; "Intracranial Neoplasms", B. O. Rand, M.D., Lexington and "Allergy in General Practice", Norman Cohen, M.D., Louisville. The entire program will consist of eight topics of interest to general practitioners in the state.

Dr. Barrett to Head Dermatologists

Carey C. Barrett, M.D., Lexington, was chosen the president-elect of the Kentucky Dermatological Society on Thursday, September 22 at the Society's meeting held during the KMA Annual Meeting in Louisville. William E. McDaniel, M.D., Lexington, was elected Secretary of the Society.

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Dr. Woodard, Ky. Orthopaedic Head

At the Tuesday, September 20 meeting of the Kentucky Orthopaedic Society, which took place in Louisville at the time of the KMA Annual Meeting, Robert Woodard, Jr., M.D., Louisville, was elected president of the Society. O. James Hurt, M.D., Louisville, was elected vice-president and Wayne W. Kotcamp, M.D., Louisville, was elected secretary-treasurer.

Psychiatrists Elect Dr. Farabee

Dale Farabee, M.D., Lexington, was named president-elect at the Thursday, September 22 meeting of the Kentucky Psychiatric Association in Louisville, coinciding with the KMA Annual Meeting. Harvey R. St. Clair, M.D., Louisville, assumed the office of President of the Association. Ray Hayes, M.D., Lexington, was elected secretary, and Louis Foltz, M.D., Louisville, was elected to serve as a delegate to the Assembly of District Branches of the American Psychiatric Association.

Ky. E. E. N. T. Soc. Elects Officers

The Kentucky State E. E. N. T. Society elected its officers for the year on Thursday, September 22, during the KMA Annual Meeting in Louisville. James O. Willoughby, M.D., Bowling Green, was installed as the president of the Society. Harry A. Pfingst, M.D., Louisville, was named president-elect, and Gerald D. Landau, M.D., Louisville, was elected secretary.

Radiologists Announce Officers

The Kentucky Radiological Society elected its officers on Thursday, September 22, in Louisville, during the KMA Annual Meeting. Robert Shepard, M.D., Lexington, will be installed as president of the Society in March of 1967. H. Q. Davis, M.D., Louisville, president-elect, will assume office in March of 1968. The newly elected secretary, Robert Greenlaw, M.D., Lexington, will take office on March 1, 1967. The other officer elected by the Society was Frank Betchel, M.D., Louisville, Counselor.

A. D. Doak, M.D., Shelbyville general practitioner, has joined the Veteran's Administration, at a hospital in Johnson City, Tenn. He graduated from Harvard Medical School in 1933 and served his internship at Johns Hopkins and Duke University. He began his practice in Shelbyville in 1936. In 1941 Doctor Doak's practice was interrupted by World War II, when he served in a medical capacity with the U.S. Army overseas. In 1945 he left Shelbyville to serve one year in Seattle with the Veteran's Administration.

Frankly, most antihypertensives are pretty good if you give an adequate dose. I'm looking for one with a simple regimen so that mix-ups in doses and therefore the chance of side effects are minimized.



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Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

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Councils and Committees of the Councils, Standing and Miscellaneous Committees for the 1966-1967 Associational Year

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Roderick Macdonald, Jr., M.D., Louisville
Thomas R. Marshall, M.D., Louisville
Willett H. Rush, M.D., Frankfort

Scientific Program Committee

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Richard R. Crutcher, M.D., Lexington
Robert E. Pennington, M.D., London
Ray J. Timmerman, M.D., Newport
J. Sankey Williams, M.D., Nicholasville

Golf Committee

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McHenry S. Brewer, M.D., Louisville
Merle W. Fowler, Jr., M.D., Paducah
P. B. Hall, M.D., Paintsville
Edward G. Houchin, M.D., LaGrange
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D. Maurice Royalty, M.D., Lexington
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C. Wayne Franz, M.D., Ashland
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Maternal Mortality Study

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Glenn W. Bryant, M.D., Louisville
Joe M. Bush, M.D., Mt. Sterling
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Jorge Deju, M.D., Frankfort
William C. Durham, M.D., Louisville
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Oliver H. Fearing, M.D., Ashland
Doane Fischer, M.D., Harlan
Lewis Francis, M.D., Lexington
John W. Greene, Jr., M.D., Lexington
Robert J. Griffin, M.D., Lexington
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Douglas M. Haynes, M.D., Louisville
Lawrence T. Hiltz, M.D., Covington
Charles E. Hornaday, M.D., Owensboro
Robert L. Houston, Jr., M.D., Eminence
Peggy J. Howard, M.D., Louisville
George C. McClain, M.D., Benton
Clarence J. McGruder, M.D., Henderson
Robert A. Orr, M.D., Mayfield
John A. Petry, M.D., Fern Creek
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Barton L. Ramsey, Jr., M.D., Somerset
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M. Harper Wright, M.D., Bowling Green

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NEWS ITEMS

D. Y. Keith, M.D., Paducah general practitioner, has started a practice limited to psychiatry in Paducah. He graduated from the University of Louisville in 1944, and completed his residency at the U.S. Marine Hospital in New York City in 1945. He completed his resident training at Jackson Memorial Hospital, Miami, Florida, in 1963.

Warren P. Jurgenson, M.D., deputy medical officer in charge of the U.S. Public Health Service Hospital in Lexington since 1962, has been transferred to Fort Worth, Texas.

William N. Blalock, M.D., has entered practice in Paducah. Doctor Blalock will limit his practice to gastroenterology and internal medicine. He graduated from Washington University Medical School in 1952, completed his internship at Barnes Hospital, St. Louis, Missouri, in 1953, his internship at Barnes Hospital in 1954, and resident training provided by a Fellowship in medicine in 1955. Prior to coming to Paducah, Doctor Blalock was Chief Resident in Medicine at City Hospital, St. Louis, and practiced at Grant Medical Clinic in St. Louis.

John C. Bates, M.D., Elizabethtown, has assumed the practice of James A. Sabens, M.D., Scottsburg, who has entered graduate training in surgery at the Mayo Clinic, Rochester, Minnesota. Doctor Bates graduated from the University of Louisville in 1952, and completed his internship at Louisville General Hospital and in Grundy, Virginia. Doctor Bates has practiced in Elizabethtown for the past eleven years.

Erwin W. Straus, M.D., psychiatrist at the Veteran's Administration Hospital in Lexington, received an unusual gift for his 75th birthday. The gift was a book containing a collection of papers written to Doctor Straus or about him, by twenty-two of the world's foremost authorities in psychiatry; all friends or one time associates of Doctor Straus. Doctor Straus has been on the faculties of the University of Berlin, Wurzberg, North Carolina, Kentucky, Louisville, and he is now a research consultant at the hospital in Lexington.

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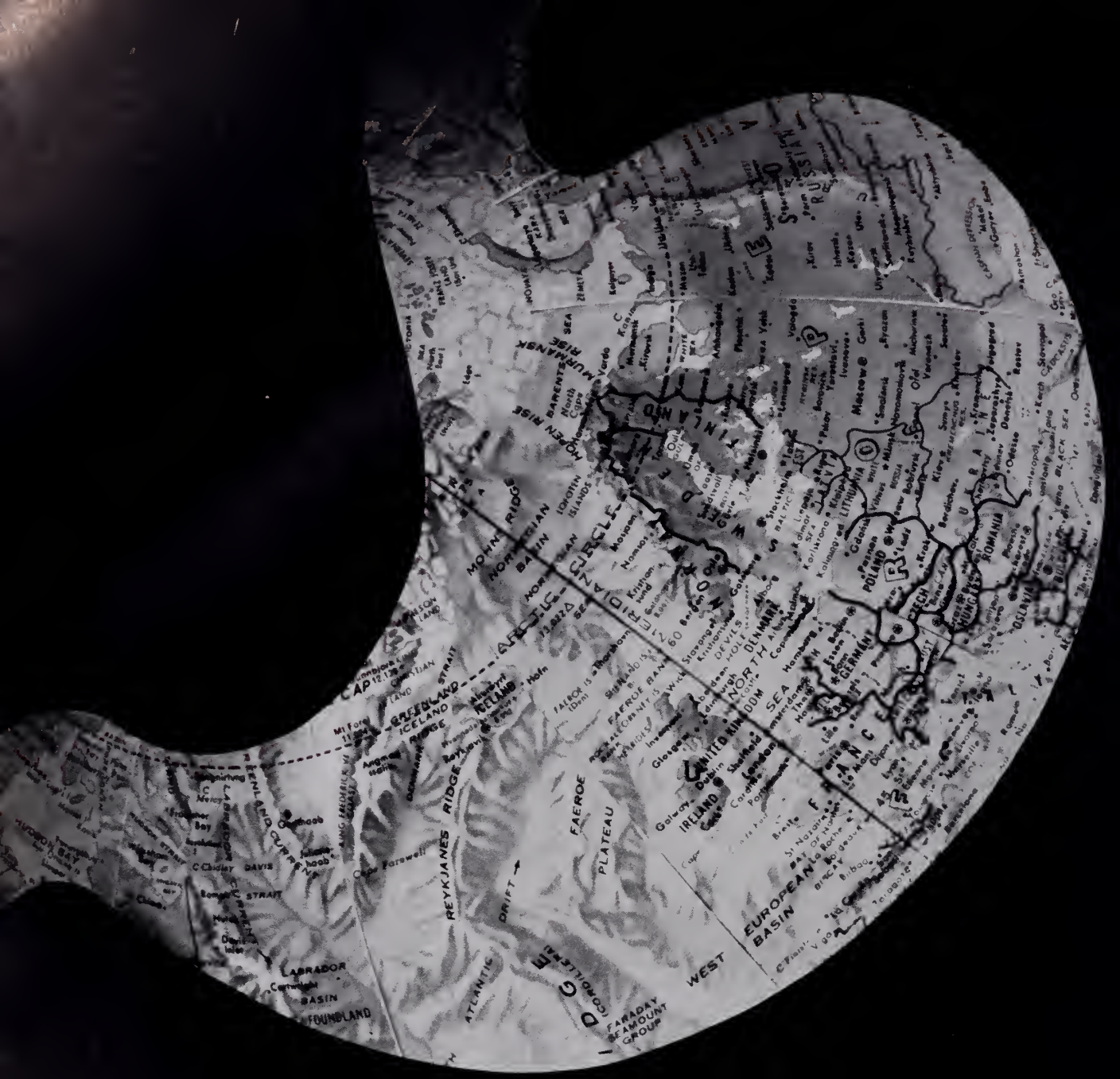
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The "Socio-geographic" mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.[3-8] Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."[3]

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References: **1.** Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. **2.** Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. **3.** Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. **4.** Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. **5.** Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. **6.** Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. **7.** Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. **8.** Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. **9.** Epstein, J. H.: Ibid 37:295 (Mar.) 1962. **10.** Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. **11.** Slanger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. **12.** Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. **13.** Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. **14.** Fleshler, B.: J New Drugs 2:211 (Jul.-Aug.) 1962.

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In Memoriam

EMERY YELTON, M.D.
Germantown
1882-1966

Emery Yelton, M.D., 84, Germantown, Kentucky, who had practiced medicine for fifty-five years in the Germantown area, died October 20 in a nursing home at Alexandria, Pennsylvania. Docton Yelton graduated from the University of Cincinnati College of Medicine in 1907. He was past vice-president of the Bracken County Medical Society and a board member of the Bracken County Health Department.

ALPHONSO NINO GUIGLIA, M.D.
Louisville
1901 - 1966

Alphonso Nino Guiglia, M.D., 65, chief psychiatrist for the Louisville Veteran's Hospital, died Wednesday, November 9 at his home. He graduated from the University of Louisville Medical School in 1929, and was a captain in the U.S. Army Air Corps during World War II. Doctor Guiglia taught psychology at the University of Louisville for thirty years. The Guiglia family had been associated with the U of L Medical School for more than 100 years.

HARRY V. JOHNSON, M.D.
Georgetown
1881-1966

Harry V. Johnson, M.D., 85, Georgetown surgeon, died Sunday, October 9 at his home, following a brief illness. Doctor Johnson graduated from the University of Colorado School of Medicine in 1906 and completed his internship at Denver and Rio Grande Community Hospitals in 1907. He served in W.W. I as a first lieutenant in the Medical Corps, and helped establish the John Graves Ford Memorial Hospital in Georgetown soon after the War. He was a past president and secretary of the Scott County Medical Society and a member of KMA.

W. RHODES McMILLEN, M.D.
Covington, Ky.
1911 - 1966

W. Rhodes McMillen, M.D., 55, Covington general practitioner, died Thursday, October 13 at his home. Doctor McMillen graduated from the University of Cincinnati in 1950, and completed his internship at St. Elizabeth Hospital in Covington in 1951. He has practiced in Covington since 1951.



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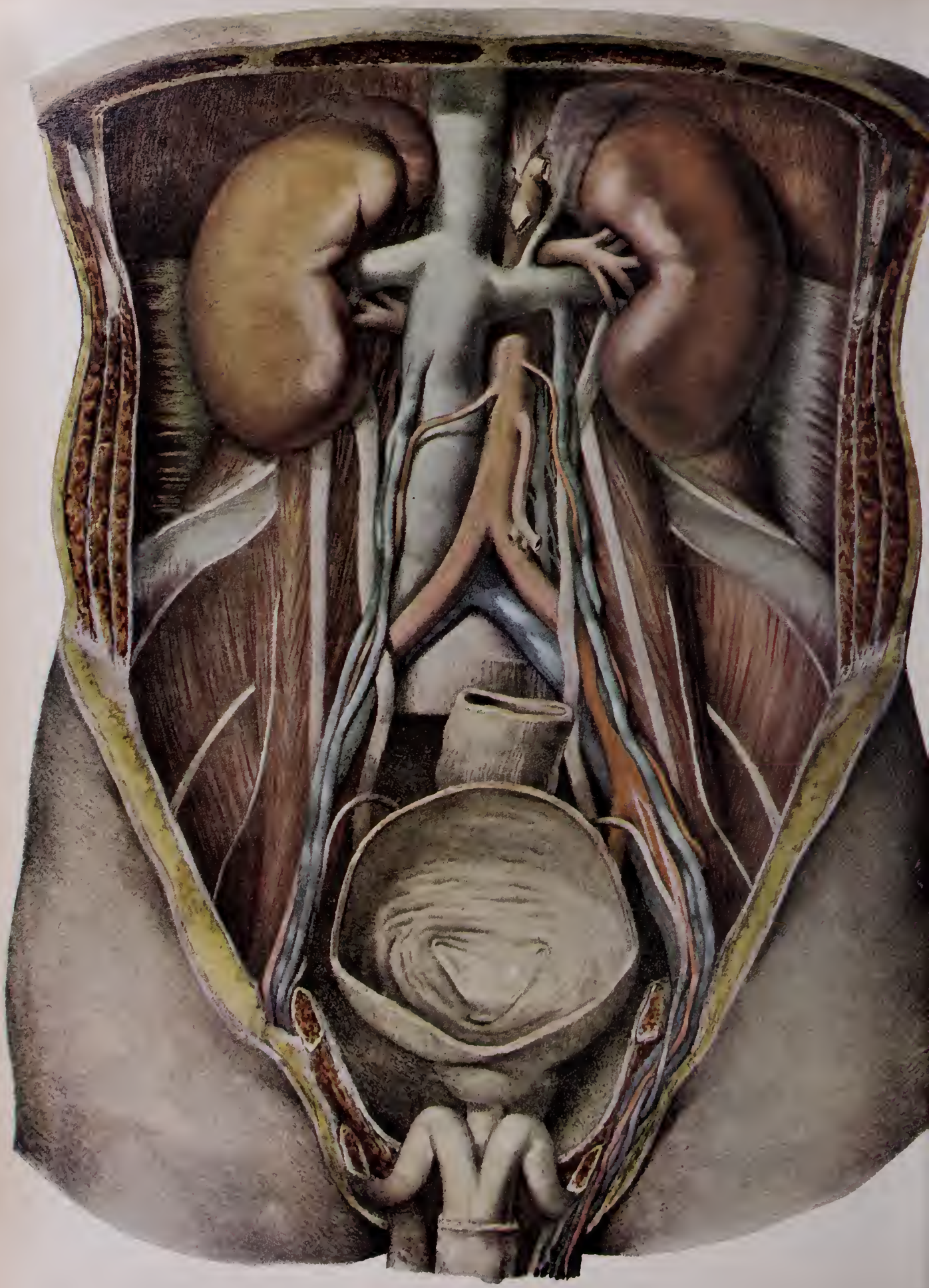
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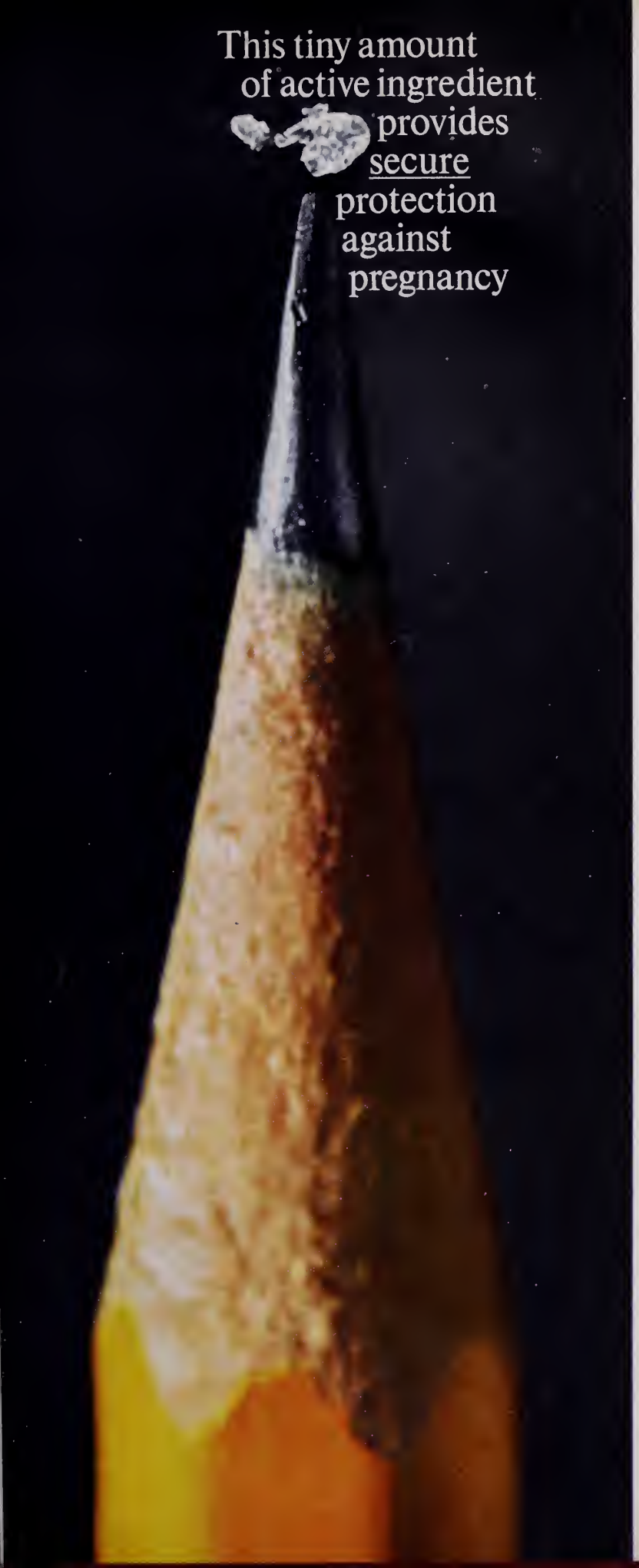
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Massive, worldwide clinical experience

Weight gain as infrequent as weight loss

New freedom from undesirable effects

New low cost

Contraindications—Mammary or genital carcinoma should be ruled out prior to administering Ovulen. Undiagnosed vaginal bleeding is also a contraindication to Ovulen use. A history of thrombophlebitis or pulmonary embolism, or both, is a contraindication to the use of Ovulen, unless its use is judged by the physician to be necessary despite the possible risk. Ovulen should not be used in women with suspected or overt liver dysfunction or disease. Ovulen is contraindicated in pregnant and nursing women and in patients with a history of cerebrovascular accident.

Warnings—Medication should be discontinued pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. Medication should be withdrawn if examination reveals papilledema or retinovascular lesions. Since the safety of Ovulen therapy in pregnancy has not yet been established, it is recommended that, in a patient who has missed two consecutive menstrual periods, pregnancy be ruled out before oral contraceptive therapy is continued.

Precautions—Because Ovulen may aggravate a tendency toward fluid retention in some patients, it should be administered cautiously to patients with a history of renal or cardiovascular disease (including hypertension), asthma, epilepsy or migraine. Any possible influence of long-term Ovulen therapy on pituitary, adrenal cortical, ovarian, hepatic or uterine functions requires further study. Oral contraceptives also should be administered cautiously to diabetic patients since a decrease in glucose tolerance has been observed in some patients taking these drugs. Patients on Ovulen may occasionally show abnormal glucose tolerance tests, but this does not necessarily indicate the presence of diabetes. Significant increases in platelet count, prothrombin and proconvertin tests, plasma thrombotic activity and plasma proteolytic activity have been reported.

Since estrogens may affect results of serum protein bound iodine and other thyroid function tests, these tests should not be considered definitive until Ovulen therapy has been discontinued for at least sixty days. Adrenal steroid serum levels and excretion may be affected by estrogens; the Metopirone® (SU-4885) test of pituitary-adrenal function may also be depressed. Abnormalities in hepatic function tests have also been reported, including some interference with dye excretion by the liver. This interference may give rise to Bromsulphalein® retention and jaundice in susceptible individuals. Serious liver dysfunction should be ruled out before continuing Ovulen administration when abnormalities in liver function tests occur.

Patients with a history of psychic depression should be observed carefully during treatment with oral contraceptives, and such treatment should be discontinued if depression recurs to a serious degree. Pre-existing fibroids may increase in size during Ovulen therapy. Such fibroids may regress to pretreatment size after Ovulen is stopped. In the event of breakthrough bleeding the possibility of nonfunctional causes should be borne in mind. Additional means of contraception should be used during the first seven days of Ovulen administration in the first treated cycle, because early ovulation may possibly occur.

Side Actions—The following adverse reactions have been reported with Ovulen; however, a causal relationship to Ovulen administration has not been established in all of the listed complaints: headache, dizziness, depression, breast complaints, amenorrhea, chloasma, vomiting, allergy, edema, migraine, pulmonary embolism, thrombophlebitis, visual difficulties, nervousness, rash, itching, decrease in libido, tiredness, malaise, hair loss and hair growth. A small incidence of nausea, spotting and breakthrough bleeding has been reported; these complaints tend to diminish markedly or disappear after the first cycle of treatment. Some of these side actions have required discontinuance of the drug.

Dosage—One tablet daily for 20 consecutive days beginning 5 days after the onset of menstruation.

Before prescribing see Detailed Product Information, Ovulen.

An extensive list of references on Ovulen is included in the literature mailed to physicians.

Research in the Service of Medicine
G. D. SEARLE & CO.
P.O. Box 5110, Chicago, Illinois 60680

SEARLE

Ovulen®

1 mg.

Each tablet contains:
ethynodiol diacetate 1 mg
mestranol 0.1 mg.

There is no more effective contraceptive available



why wonder about a drug

when you know

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE
is effective b.i.d.



It's made for b.i.d.

Effective in a wide range of everyday infections — respiratory, urinary tract and others — in the young and aged — the acutely or chronically ill — when the offending organisms are tetracycline-sensitive.

Contraindication — History of hypersensitivity to demethylchlortetracycline.

Warning — In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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Everyone says she's a barrel of fun



But what does she think?



Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

Bamadex® Sequels®

DEXTRO-AMPHETAMINE SULFATE (15 mg.) WITH MEPROBAMATE (300 mg.) SUSTAINED RELEASE CAPSULES

to help establish a new dietary pattern

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or ore severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such os anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxio, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drawsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitont administration of central stimulants. Allergic ar idiosyncratic reactions: maculopopular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, practitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, como, shock, vasomotor and respiratory collapse.

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A Division of American Cyanamid Company,
Pearl River, New York

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The comfortable way to get well...™

When headache, fever, pain, malaise accompany bacterial URI

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WITH BRISTAMIN®

(tetracycline phosphate complex with analgesics and antihistamine)

With a single prescription, you can add all the known benefits of Tetrex (tetracycline phosphate complex) to the traditional relief provided by APC. At the same time Bristamin (phenyltoloxamine citrate), provides relief of allergic symptoms—watery eyes, rhinorrhea and congestion.

BRISTOL THERAPEUTIC SUMMARY. For complete information, consult Official Package Circular. *Indications:* Upper respiratory infections due to sensitive bacteria where concomitant symptomatic relief of fever, malaise and congestion is desired. *Contraindication:* A past history of hypersensitivity to one or more components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Antihistamines may cause drowsiness and patients should not perform tasks requiring mental alertness while taking this agent. Bacterial or mycotic superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for three months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. *Usual Adult Dose:* Two capsules q.i.d. Continue therapy for at least 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Bottles of 24 and 100.

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BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York

1966 CONSTITUTION AND BYLAWS
OF THE
KENTUCKY MEDICAL ASSOCIATION

Revised September 21, 1966

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such

methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."
(b) "Annual Meeting" means the annual three-day meeting of the Association.
(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.
(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.
(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Discipline—The Judicial Council
Chapter VIII. Standing Committees and Councils
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CHAPTER I. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.
(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.
(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of

Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

Section 5. Every new active member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within two years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component society, and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurels, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 4, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker of the House of Delegates, the Vice-Speaker of the House, the Secretary and the Treasurer shall be elected for terms of three years. The Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when

the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 5. The Journal of the Kentucky Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the

Judicial Council shall be of the opinion that the offending member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

At the request of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation, intervention, or supersession, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recomendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

CHAPTER VIII, STANDING COMMITTEES AND COUNCILS

Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of six standing committees and or boards or commissions composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws.
(b) A Committee on Arrangements for the Interim Meeting.
(c) An Advisory Committee to the Editor of the Journal.
(d) A Board of Managers of the McDowell House.
(e) An Insurance Review Board.
(f) A Memorials Commission.

Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Governmental Medical Services.

Section 3. The Executive Committee shall serve as the nominating committee for all Standing Committee and Council appointments, but the Trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President shall serve as Chairman.

Section 4. Except as otherwise provided herein, members of Standing Committees and Councils shall be appointed for terms of not less than one year nor more than three years, and until their successors are appointed. Each committee and council (other than the Council on Scientific Assembly) shall meet and organize as soon after its appointment as possible, and shall meet again near the close of the associational year, for the purpose of formulating its annual report. It may meet at such other times as may be necessary or desirable. The Headquarters Office shall be the headquarters for all committees and councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee, and all notices of committee meetings shall issue

from the headquarters office at the direction of the chairman.

Five-member Committees and Councils shall have a quorum of three, and seven-member Committees and Councils shall have a quorum of four members present before any business other than the fixing of the time and place of the next meeting, may be transacted.

All committees, other than standing committees, shall be assigned to a council and shall report their activities and recommendations *only* to the council to which assigned. These reports will be reviewed by the various councils and no such reports or recommendations will be considered by the Board of Trustees unless and until reviewed by the proper council.

Each Standing Committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted, without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. Committees and Councils may submit supplemental reports if such reports are in the hands of the Secretary at least 48 hours in advance of the first meeting of the Regular Session of the House of Delegates.

Section 5. The President, Secretary, and Executive Secretary shall be exofficio members of all Committees and Councils, without power to vote except as otherwise specified herein.

Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. No committee shall be composed of more than seven members unless specifically so provided by the Board. All such committees shall expire at the end of the Associational year unless earlier dissolved by the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. The Committee to Study the Constitution and Bylaws shall make a continuing study of the Constitution and Bylaws and shall annually recommend such revisions of either or both of these documents as changing times and conditions indicate.

Section 8. The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Section 9. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Section 10. The Insurance Review Board shall provide a forum in which disputes between physicians, their patient-insureds, and insurance carriers can be mediated.

Section 11. The Board of Managers of the McDowell House shall be responsible for the proper maintenance and operation of the McDowell House and Apothecary Shop under the general guidance of the Board of Trustees.

Section 12. The Memorials Commission shall endeavor to finance the furnishing of the Board Room and the President's Office, may accept memorial contributions to the Association and collect books, medical instruments and other memorabilia associated with the early practice of medicine for inclusion in the display on exhibition in the President's Office.

Section 13. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Section 14. The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Association Education Research Foundation, and concerning itself with problems relating to non-governmental medical and hospital care, general practice, research and such other matters in this general field as may be referred to it by the Board.

Section 15. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its consideration. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Section 16. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc. and Blue Cross plans. It shall serve as a clearing house on all non-governmental fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care to all segments of the population through physician placement and other means.

Section 17. The Council on Communications and Public Service shall supervise and direct all Associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, highway safety, disaster medical care and diabetes. In addition, it shall assist the Board in presenting the Orientation Course referred to in Chapter I, Section 5.

Section 18. The Council on Governmental Medical Services shall concern itself with all programs of medical care offered by governmental agencies, maintaining close liaison with the State Department of Health and other governmental units involved with such programs. It shall keep the Board of Trustees informed of all innovations in the field of governmental medicine and advise the Board as to any action which the Association should take with regard to such programs.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $75, except Active Members who devote all of their time to teaching or research and have no private practice, $50.00; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association, and shall be classified in accordance with Chapter I, Section 2 of these Bylaws. Provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

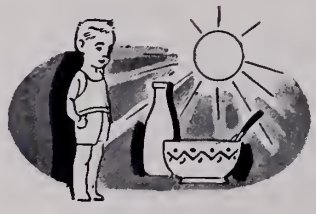
Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XIII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.



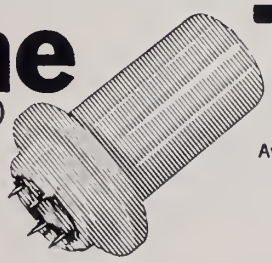
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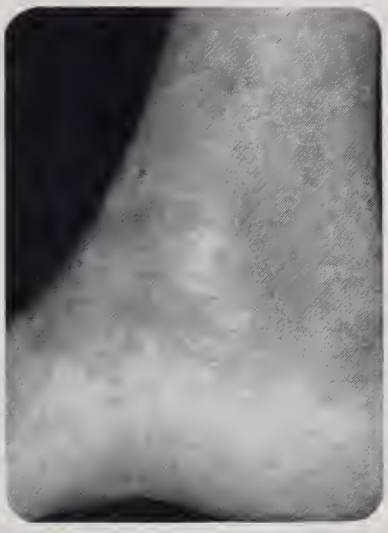
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MOLECULAR REMODELING—

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More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acctazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

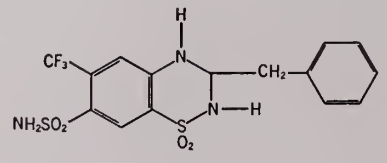
Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

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Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.

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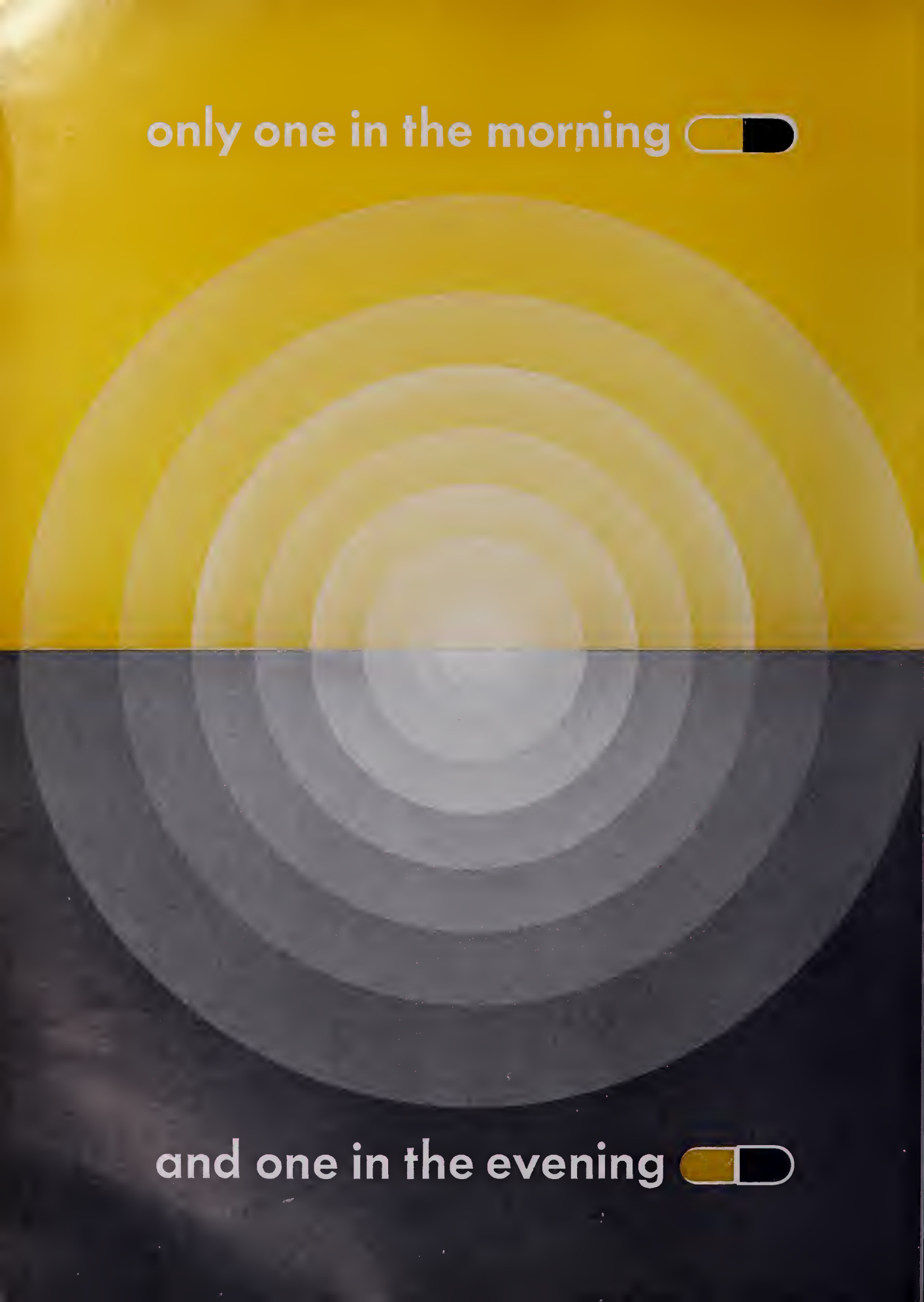
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Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuhoric, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

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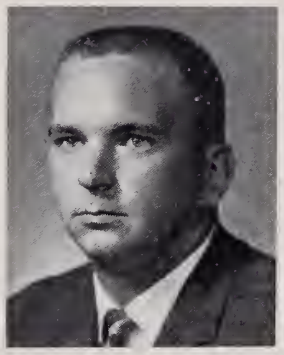
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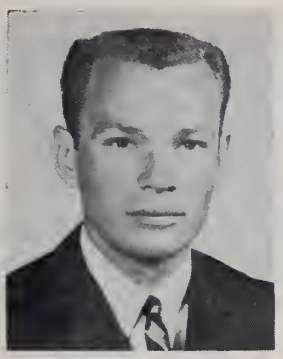
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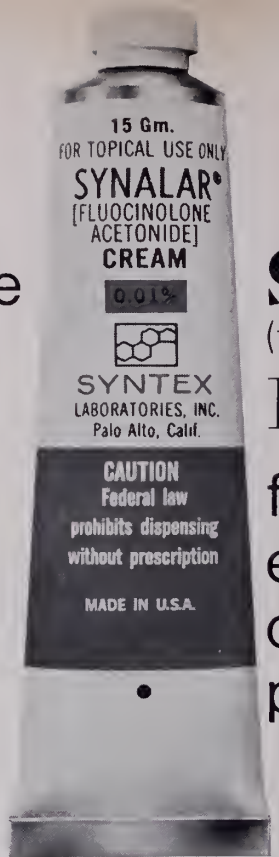
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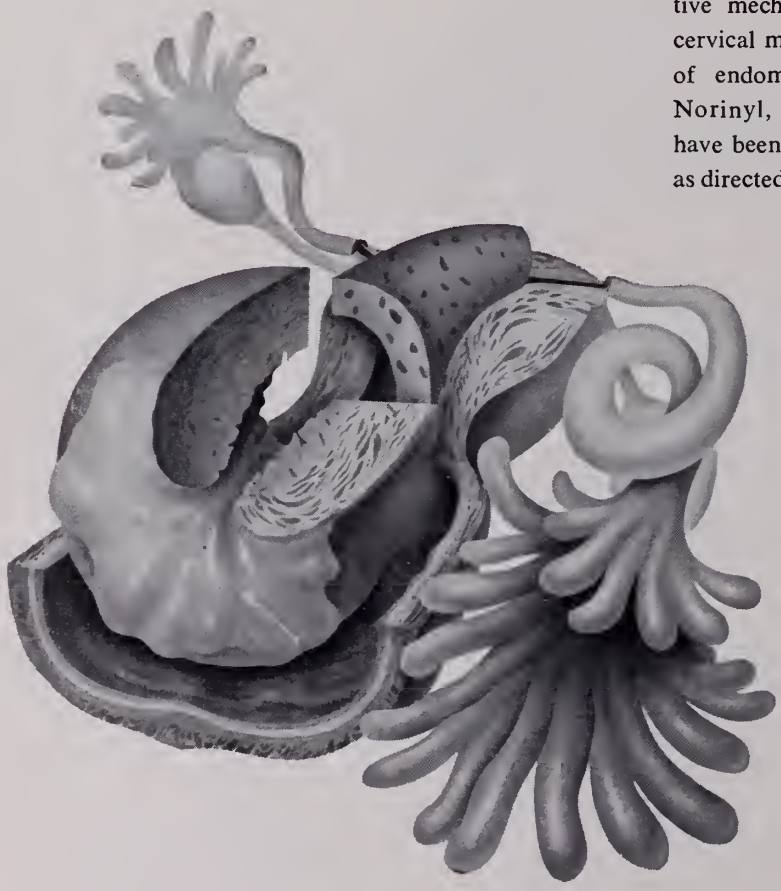
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Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov) 1965. 5. Hammond, D. O.: Ibid 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M : Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr : N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, O. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

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KMA Council and Committee Reports

KMA Technical Advisory Committee on Indigent Medical Care

Garnett J. Sweeney, M.D., Liberty, Chairman

KMA Headquarters Office **November 9 and 17, 1966**

The first meeting of the KMA Technical Advisory Committee on Indigent Medical Care was held on November 9 with representatives of the Kentucky Hospital Association, Blue Cross-Blue Shield, the Director of the Department of Medical Assistance, Mr. Evan Ray, the Commissioner of Health, Russell E. Teague, M.D., and G. L. Simpson, M.D., chairman of the Governor's Advisory Council.

This was an introductory meeting to review the present and expanded phases of Title XIX.

A special meeting of this committee was also held on November 17, 1966, with representatives of the Department of Medical Assistance and Mr. Don Smith of the Metropolitan Life Insurance Company's Medicare Claims Office in Lexington, to try to simplify the procedures for Title XIX buying into Title XVIII.

Governmental Medical Contracts Committee (ODMC-Home Town)

L. Douglas Atherton, M.D., Louisville, Chairman

KMA Headquarters Office **November 3, 1966**

The Governmental Medical Contracts Committee met with Brigadier General Norman E. Peatfield, M.C., Executive Director of the Office for Dependents' Medical Care (ODMC), and his assistant, Lt. Colonel William Bunge, from Denver, Colorado at the KMA Headquarters Office on November 3.

Present, expanded and future contracts with the ODMC were discussed. It was agreed that as soon as practicable, all contracts would be written on the basis of usual and customary fees.

Council on Governmental Medical Services

Paul J. Parks, M.D., Bowling Green, Chairman

KMA Headquarters Office **November 9, 1966**

The new Council on Governmental Medical Services met at the Headquarters Office on November 9, 1966, with Howard W. Dean, M. D., Assistant Director of the AMA Division of Socio-Economics and James H. Fleming, an AMA staff member of this division. The government programs were explained in detail by the AMA representatives. Assignments were then made to the committee and the council in an effort to eliminate overlapping or duplication.

Plans were made for the committees serving under the Council.

COUNTY SOCIETY REPORTS

McCracken

The regular meeting of the McCracken County Medical Society was held at Boswell's Restaurant on the night of October 26.

The business meeting was called to order by the president, Walter Johnson, M.D., at 7:30 P.M.

The application of Curtis Bippert, M.D., to membership in the McCracken County Medical Society was approved unanimously.

The County Health Officer gave a report regarding a recent outbreak of an infection at Jackson Grammar School. After discussion by members of the County Society, it was agreed that the infection was more than likely the result of a viral enteritis. Doctor Sergent discussed the role of the Health Department in registration and clinical studies performed on food handlers in general.

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Sixth District ..... REX E. HAYES, Glasgow 1969
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Eighth District ..... LEROY C. HESS, Florence 1969
Ninth District ..... MITCHEL B. DENHAM, Maysville 1967
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1967
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Twelth District ..... ROBERT F. LONG, Somerset 1968
Thirteenth District ..... WALTER L. CAWOOD, 1200 Bath Avenue, Ashland 1967
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Fifteenth District ..... E. C. SEELEY, London 1969

Buyers Guide

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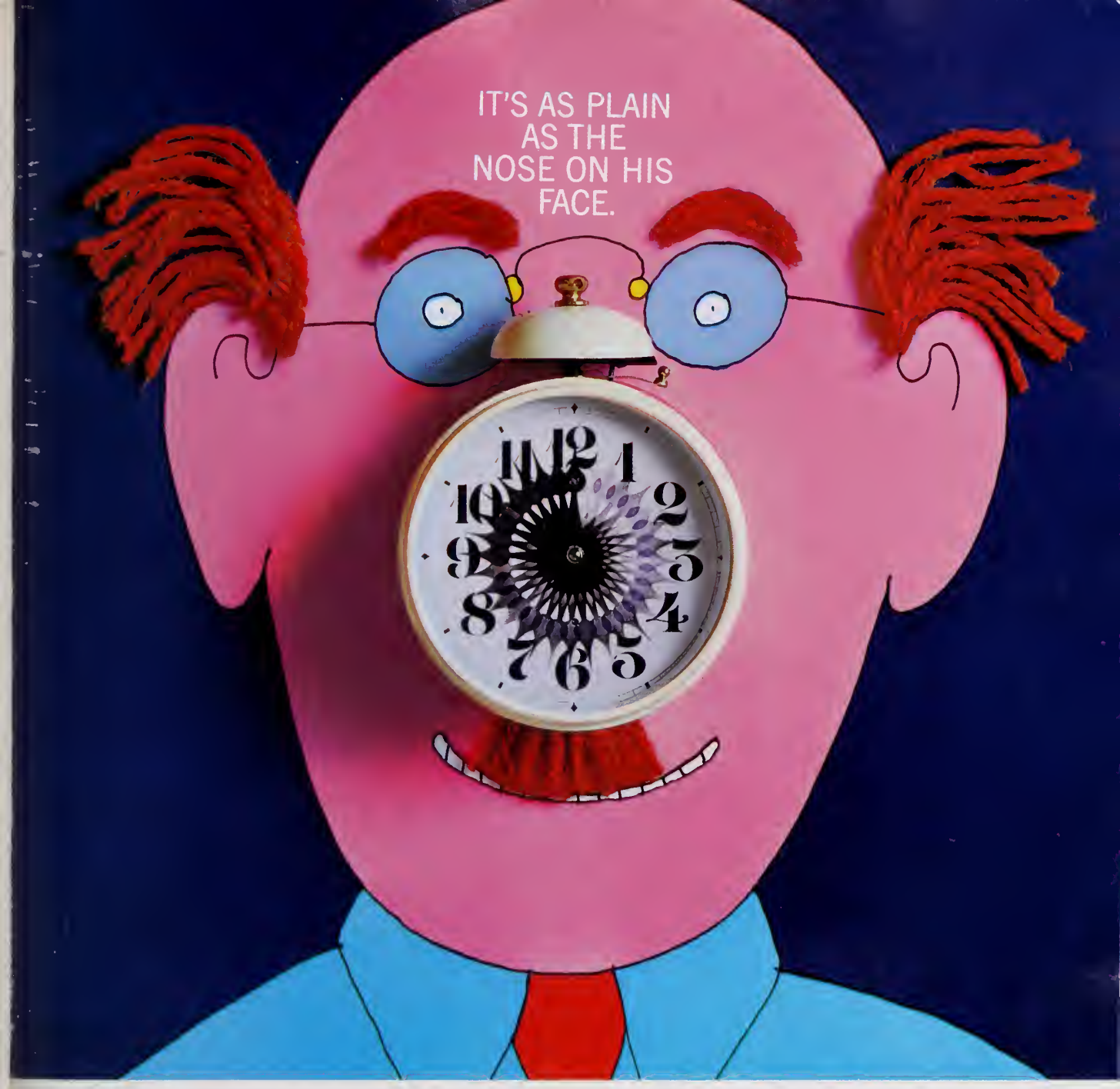
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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

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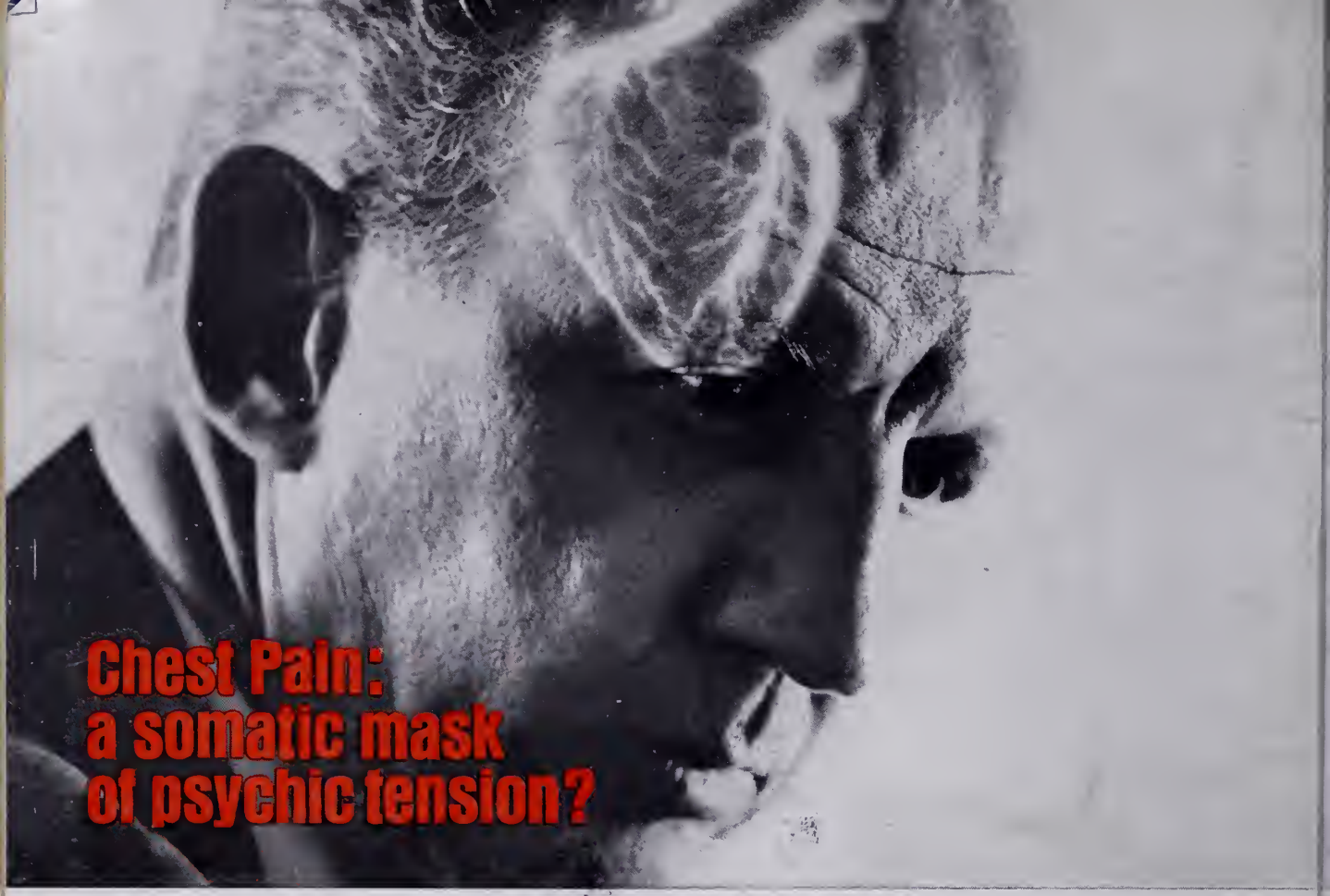
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"Heart symptoms"—chest pain, tachycardia, arrhythmia—invariably alarm and preoccupy the patient, though they may be completely without organic basis. Such symptoms often are somatic masks of psychic tension, arising from constant encounters with stressful situations.

When the problem is diagnosed as emotionally produced, consider Valium (diazepam) as adjunctive therapy. Valium (diazepam) acts rapidly to calm the patient, to reduce his psychic tension and relieve associated cardiovascular complaints.

NEUROTIC FATIGUE—the chronic tiredness resulting from emotional strain which so often accompanies psychogenic "heart" symptoms—also can be alleviated by this highly useful agent. Valium (diazepam) often achieves results where other psychotherapeutic agents have failed.

Valium (diazepam) is generally well tolerated, and usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Supplied: Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 for convenience and economy in prescribing.

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